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An Editorial

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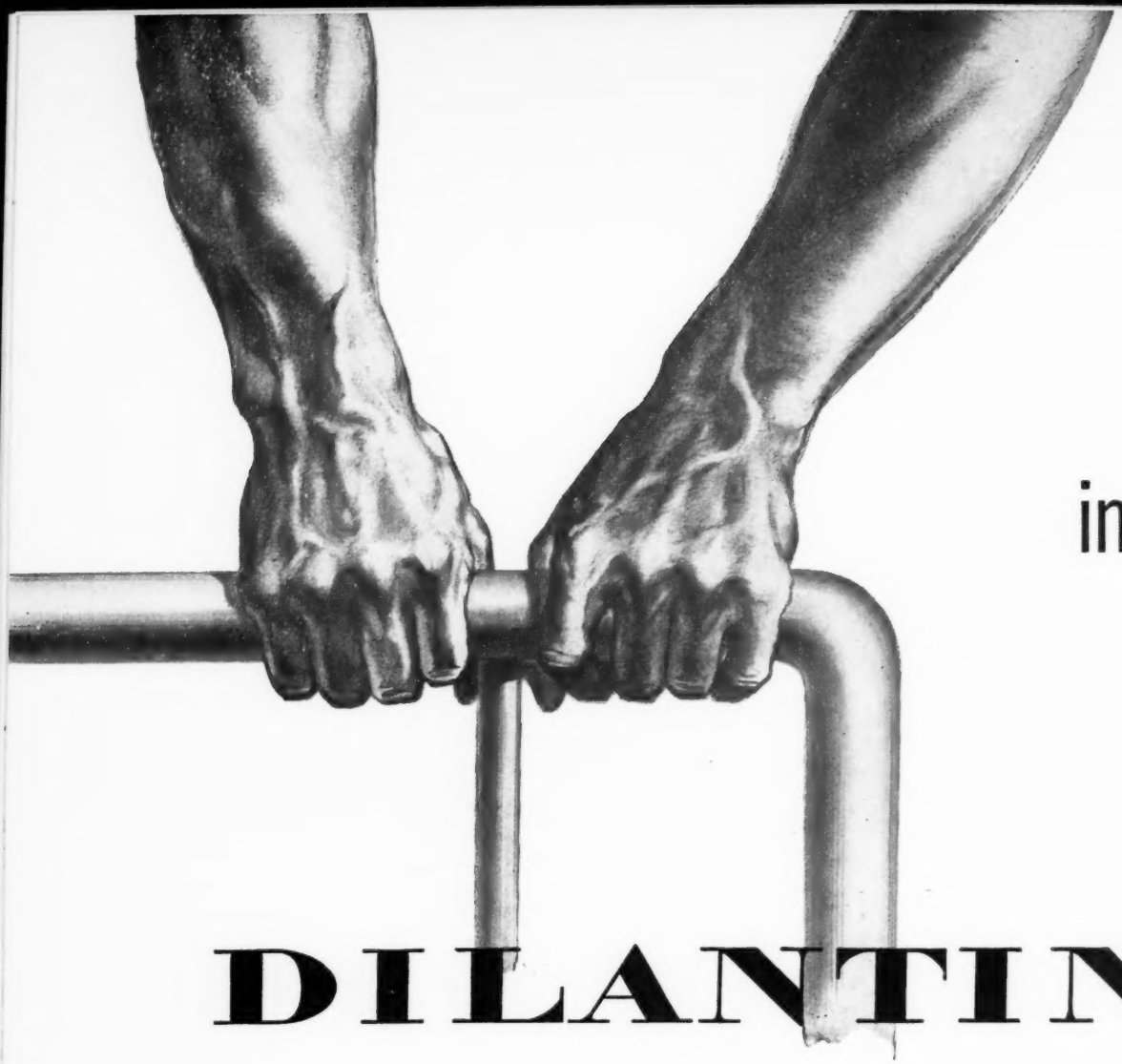

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*Cutting, W. C.: A Manual of Clinical Therapeutics, ed. 2, Philadelphia, W. B. Saunders & Co., 1948, p. 484.

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Advancing Field of Thoracic Surgery

DeWitt C. Daughtry, M.D.
AND
John G. Chesney, M.D.
MIAMI

Some of the most valuable and spectacular advances in the history of medicine have occurred recently in the field of thoracic surgery. It is interesting to recount the advances and to realize that almost the entire development of this field has occurred during the past three decades. The most dramatic developments have taken place during the latter half of this period. A majority of the surgeons who have made the fundamental contributions are still actively practicing surgery. The thoracic surgeon deserves only a small portion of the credit. Chemotherapeutic agents and antibiotics, better understanding of physiologic principles, widespread use of blood plasma and tremendous advances in anesthesia have played a great part in the development of this new and vast field of endeavor. He has devised many means of diagnosis, however, and has spent much time clarifying the previously hopelessly confused anatomy of the thorax. Three decades ago few surgeons dared open the living thorax for the general understanding was that an open thorax was synonymous with death.

In 1933, Graham performed the first successful pneumonectomy for carcinoma of the lung. It is dramatic to hear him relate the events leading to this procedure upon a fellow physician who would not submit to the pneumonectomy until he had had some dental bridgework done. The physician upon whom this first operation was performed is still actively engaged in the practice of medicine. Thoracotomy is now as common an occurrence in many of our larger hospitals as gastrectomy or resection of the colon. Early in the development of thoracic surgery, it was natural that only salvage type patients were operated upon. After improved technic and better over-all results were attained, and after the clarification of the indications, the field has expanded to include about as many procedures as are performed by the abdominal surgeon.

Read before the Florida Medical Association, Seventy-Seventh Annual Meeting, Hollywood, April 25, 1951.

Diagnostic Aids

Bronchoscopic examination, aside from radiologic study, is the single most important diagnostic procedure available to the thoracic surgeon. Its value is greatly enhanced when the surgeon is thoroughly conversant with thoracic disease, physiology, and living gross pathology of the chest, for it is now appreciated that there are many clues to pulmonary function as well as anatomic derangements to be derived. The technic itself has been extended with the addition of right angle foroblique and retrograde telescopes, and also by the development of cytologic diagnosis of malignant disease from bronchial washings.

Bronchography has undergone change and refinement in purpose. Whereas a filling demonstrating or excluding ectasia was formerly considered adequate, its goal has now become the accurate and complete study of each segmental bronchus. The result has been widespread improvement in bronchographic technic.

In addition, the harmful results of a cavalier attitude toward the instillation of iodized oil, if they are not, at least should be appreciated, for these oils in unsuitable cases are capable of producing a prolonged state of bronchitis and bronchial spasm with crippling dyspnea. In addition, nonbronchial diseases, inflammatory and neoplastic, are ill-advisedly obscured in subsequent roentgenograms. These latter objections may be met by the use of new, rapidly absorbed contrast mediums in aqueous solution for instillation or in powder form for insufflation. Introduced first in England, and about to be released commercially

here, these products are of value, but in highly accurate segmental studies, their efficacy is less than that of the present oily mediums.

Roentgen kymography is an accurate method for recording the pulsation of the heart, great vessels, and suspected aneurysms, and has been of particular use in studying constrictive pericarditis.

Angiocardiograms made after intravenous injection of diodrast, and cardiac catheterization studies yield accurate information as to cardiac function and anatomy.

Tomography or laminagraphy, though objectionable because of the expense of the equipment and of operation, is of considerable aid to the thoracic surgeon and internist, particularly in determining cavitation. It has also been shown to be the most accurate method of picking up small intrathoracic metastases which cannot be detected on routine and stereoscopic roentgenograms. This is of great importance in view of the increasing frequency with which thoracic surgeons are being called on to remove solitary metastases in the chest. In such cases, laminagraphy, if available, should be employed to rule out multiple metastases too small to appear on routine roentgenograms.

Roentgen studies following the induction of pneumoperitoneum, a procedure used by us for several years, is helpful in differentiating subdiaphragmatic from supradiaphragmatic lesions.

The greatest single advance has been the increasing appreciation of the importance of roentgenograms of the chest, even when physical signs are absent. The diminishing tendency to treat thoracic disease unguided by roentgen study has resulted in a steadily decreasing delay in diagnosis of all varieties of disease of the chest.

Surgery of the Lungs

With dwindling mortality and morbidity in surgery of the lungs, the picture of operating for "salvage" has changed to that of operating to relieve symptoms and disability early in the course of disease, and the variety of pathologic conditions that have been cured by pulmonary resection is endless. Pre-eminent, of course, is bronchogenic carcinoma. Increasingly early suspicion and rapidity of management by subjecting the patient in such cases to early bronchoscopy and exploratory thoracotomy are reflected in a steadily climbing operability and resectability rate. The outlook in this disease should not and will not under these circumstances remain as poor as heretofore.

During the last decade lobectomy for bronchiectasis became a most satisfactory procedure, and in many cases lobes were removed from each side in bilateral bronchiectasis. As experience increased, mortality dwindled, and now, in centers well equipped in staff and experience to manage these cases properly, it approaches 1 per cent. As the detailed intralobar anatomy was worked out, segmental resection of the modern type was developed. This procedure is of great help in bilateral bronchiectasis, allowing, as it does, the removal of only the involved portions while the healthy segments of the lobe are left in place. Two patients in our series had segments removed from four of the five lobes (fig. 1).

Fig. 1. — E. C., a man aged 35, had segments removed from four lobes for incapacitating bronchiectasis with good rehabilitation.

The tendency to drain abscesses, a life-saving procedure in former years, has changed greatly with the advent of the antibiotics. Vigorous medical measures will now commonly produce cure, and in the remaining cases cure may be effected by pulmonary resection. A related lesion, the congenital pulmonary cyst, which not infrequently produces pulmonary hemorrhage or becomes infected with the appearance of abscess of the lung, is also a relatively common lesion curable surgically.

Other intrapulmonary lesions which have been resected are endless in number, and each month brings reports of removal of some new tumor or inflammatory lesion. The commonest, however, are bronchial adenoma, tuberculoma, hamartoma or chondroma, arteriovenous aneurysm, and chronic granulomas of undetermined etiology. Pulmonary

adenomatosis, an apparent neoplasm or possible infectious process commonly of multicentric pulmonary origin, has recently been observed with increasing frequency.

Particular mention should be made of the surprisingly good results in resection for solitary pulmonary metastases occurring after removal of a primary neoplasm elsewhere in the body. Resection of solitary metastases from soft tissue sarcoma has yielded prolonged survival in a remarkably high proportion of the cases. Results with other sarcomas are also encouraging, and certain solitary metastatic carcinomas have been resected with occasional benefit.

Spontaneous pneumothorax with frequent recurrence is an indication for thoracoscopy for study of the pleural surface and, occasionally in younger persons, thoracotomy with resection of bleb-bearing segments or lobes, depending on the local situation.

When spontaneous pneumothorax occurs in aged persons with advanced emphysema, we have observed that pneumoperitoneum, introduced after re-expansion has occurred, serves the twofold purpose, first, of decreasing the all important residual air, thus improving respiration, and, secondly, of taking the strain off the visceral pleura, thus decreasing the chance of rupture.

Surgery of Mediastinal Tumors and Mediastinitis

Aside from lymphogranulomatous lesions of the mediastinum which can usually be diagnosed by their appearance, blood picture, node biopsy, and rapid melting within a week on a small test dose of irradiation, the common mediastinal tumors include dermoid cyst, teratoma, substernal thyroid, paramediastinal neurofibroma, pleuropericardial cyst, and less commonly, bronchogenic cyst, thymoma, lipoma and hyperplastic tuberculous nodes.

As a rule the resectability rate is high with complete cure, and, as the neoplasms mentioned all have a distinct tendency to become malignant, their prompt removal is usually advisable with the exception of the lymphogranulomas.

Mediastinitis is a disease that is increasing in frequency and commonly arises from esophageal perforation. Erosion or penetration by a foreign body may occasionally produce this situation, but far more commonly, unfortunately, the perforation is produced during esophagoscopy or dilatation. Skillful, and this implies careful, instrumentation should eliminate the majority of these tragic instances. When the telltale of pain in the back, the slightest cervical subcutaneous emphysema, minimal pleural effusion or pneumothorax occurs following esophagoscopy, extensive experience has proved that the only safe treatment is the administration of antibiotics, localization of the perforation by a swallow of iodized oil, and immediate drainage by cervical or posterior mediastinotomy. Sometimes an early perforation may be treated by primary closure if detected within the first few hours.

Spontaneous rupture is another esophageal lesion that has been diagnosed successfully a number of times. The pain, unlike that of perforation of a peptic ulcer, begins immediately after an attack of vomiting in contradistinction to the preexisting pain in peptic ulcer. There is frequently a history of consumption of much alcohol and most perforations have occurred while the patient, having a full stomach, vomited violently. The pain is agonizing and usually produces a boardlike abdomen, but unlike perforation associated with peptic ulcer, there is no air under the diaphragm. The appearance of a left pleural effusion and pneumothorax and, frequently, subcutaneous air at the sternal notch confirm the suspicion. The treatment is thoracotomy and immediate closure of the rent.

Diaphragmatic Hernia and Transdiaphragmatic Approach to the Upper Part of the Abdomen

The repair of diaphragmatic hernia is a common thoracic procedure, the chest approach giving unexcelled exposure and allowing ideal conditions for closure. The chief exception is the large posterior hernia in the newborn. In this condition it is technically easier to employ the abdominal approach, and the abdominal skin alone may be closed if necessary to ease the abdominal tension. Apropos of these remarks concerning exposure is the finding that the thoracic transdiaphragmatic approach often greatly eases the difficulty in removing a greatly enlarged spleen or kidney, while much gastric surgery and shunt operations for portal hypertension are facilitated.

Paraesophageal hiatus hernia with stasis and ulceration should be added to the list of causes of severe hematemesis. The loss may be acute or chronic and ceases when the constricted stomach pouch is released and returned to the abdomen.

At times, because of age or other factors, a hiatus hernia of small size may be considered unsuitable for reduction, in which case a left temporary phrenic crush, repeated at intervals upon

regeneration, is a valuable procedure by dint of the relaxation of the diaphragm. Permanent destruction of the nerve for such a situation is not warranted.

Surgery of the Heart

Although the removal of a constricting pericardium was accomplished in a comparatively modern manner by the German Schmieden in 1914, cardiac surgery underwent little advance in this country for many years, although shortly after World War I, a cardioscope was invented by Allen and used on dogs. In addition, about this time, Cutler operated upon 2 patients with mitral stenosis, converting the situation from one of stenosis to insufficiency. One of his patients experienced temporary betterment, but died within the year. The great surge of activity began again with the division of the ductus arteriosus by Gross[1] in 1939, which set the stage for a resurgence of interest in cardiac surgery. Shortly afterward came the well known contribution of Blalock[2] in tetralogy of Fallot and other congenital anomalies and the resection of a segment of aorta for coarctation which was first performed by Crafoord and Nylin[3] of Sweden.

At the present time, widespread research and clinical activity are directed toward the production and correction of interatrial and ventricular septal defects, and the conversion of stenotic valves into functioning ones by auricular, and ventricular approaches, a procedure applicable to both congenital derangements and the acquired lesions of rheumatic fever. There has been renewed interest in the development of cardioscopes to visualize and operate upon the interior of the chambers and valves. These instruments depend, in general, on pressure of the optical system against the object viewed to clear the field of blood, or upon intermittent jets of water associated with removal of blood to prevent cardiac strain. There are also numerous groups working on the problem of diversion of the blood past the heart by means of a mechanical heart and lung (extracorporeal circulation), the purpose being to allow, for a short period, direct surgical attack on the heart. Revascularization experiments depending on anastomosis of systemic arteries to the coronary sinus and burial of systemic arteries in the myocardium are also being carried out with some promise of success beginning to appear both in experimental animals and in man.

An important development just coming to hand is the development of arterial grafting already used with success by Gross, Bill and Peirce[4] in bridging the gap left in the aorta after resection of a long coarctation, and also successfully applied by Lam[5] in replacing a 6 inch segment of the thoracic aorta removed because of a saccular aneurysm. The result of this experience with grafts has led directly to the investigation of stored or bank grafts kept for varying periods of time in electrolyte solutions at various temperatures and the present preservation by lyophilization methods. The technical and legal pitfalls in the problem have been partially overcome, and the day of arterial banks has arrived. Progress toward the establishment of such a bank in the Miami area has been made.

The rarity of success by highly skillful, forward surgeons using such methods of bridging arterial gaps as the vein-lined tantalum tube during World War II is in great contrast with the high degree of success apparently possible with stored arterial grafts, and makes the working out of these problems and the development of such banks of particular importance in these uncertain times.

Surgery of the Esophagus

Long after the surgery of the remainder of the gastrointestinal tract had been developed to a high degree of perfection, the esophagus was considered too inaccessible an organ for surgical therapy in view of the great problems imposed. Among these in particular were its location in the thorax, and the peculiar blood supply of this organ which prevented resection and an anastomosis of the mobilized ends as in the intestines and colon. The modern type of resection of the esophagus for carcinoma was developed by Adams and Phemister[6] in the late thirties with lesions of the lower third of the esophagus.

Several years later, the stomach was mobilized sufficiently to allow the removal of a lesion at the aortic arch with anastomosis above the arch. It has now been demonstrated by a number of surgeons that the entire esophagus can be removed and the stomach may be brought up through the chest into the neck and anastomosed to the cervical esophagus or pharynx through a separate cervical incision. Despite the tremendous mobilization of the stomach necessary for such a transplantation, the blood supply remains adequate. A less widely known and utilized procedure developed by Wookey is applied in certain cases of the cervical esophagus in which the foregoing procedure is considered inadvisable, and in the Wookey procedure

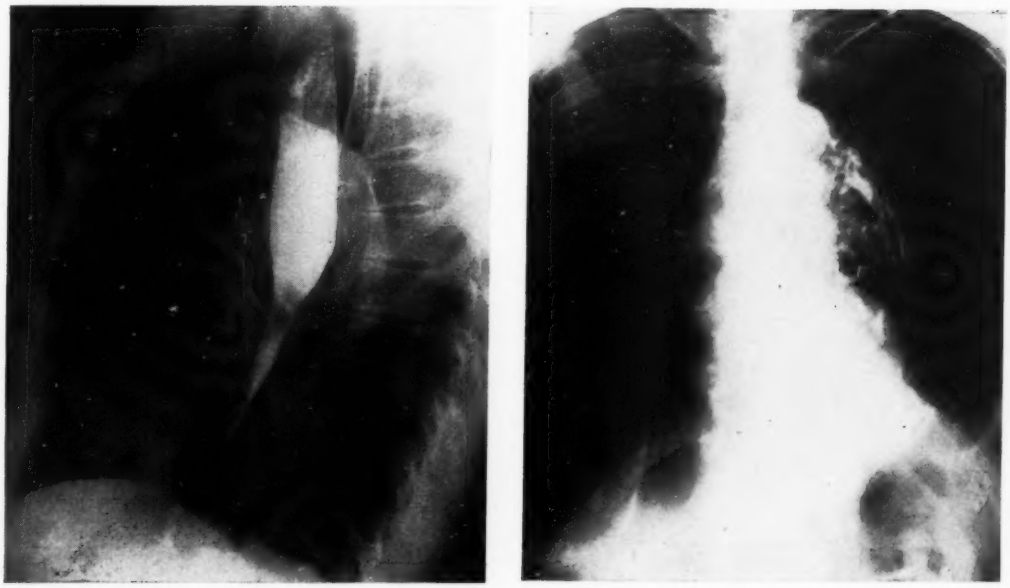

Fig. 2. — C. H., a man aged 63. A. Carcinoma, middle third of the esophagus. B. After esophageal resection and supra-aortic esophagogastrostomy.

the cervical esophagus and tumor are removed leaving a cervical pharyngostomy and esophagostomy, the continuity of the esophagus being reestablished by buried skin tubes partially produced at the initial operation and closed at a second (fig. 2).

Another esophageal lesion now occasionally submitted to surgery with good initial results is the persistent cardiospasm that fails to respond to dilatation. In cases of this type an esophagastric plastic procedure has been used to good advantage in correcting obstructions, and in our hands immediate results have been generally good. Long term results are not yet available though peptic esophagitis with bleeding has been reported by others.

Congenital atresia of the esophagus with tracheoesophageal fistula in the newborn, a condition with a hopeless prognosis, is now correctible provided the diagnosis, which is readily made, is arrived at promptly and the infant is brought to surgery within the first few days of life. The condition demands division and closure of the tracheoesophageal fistula with mobilization and anastomosis of the proximal and distal segments of the esophagus. This procedure has completely replaced the multiple stage fashioning of anterior thoracic skin tubes leading from a pharyngostomy to a gastrostomy. In our opinion the right extrapleural approach of Haight and Towsley[7] used in their historic first case in 1943 or its various modifications offer greater safety in the event of anastomotic leakage than the transpleural approach. The technical problems are somewhat greater, but the increased safety in the event of leakage makes it well worth while.

If choking on the first feeding associated with cyanosis occurs in the newborn, this condition should be immediately suspected. It can be confirmed at once by demonstrating high obstruction of the esophagus by simply introducing a gavage tube. If obstruction is present, its location can be confirmed by roentgen examination with the tube in place, and all efforts then should be directed toward saving time, for with each hour the infant's condition can only become worse. Lipiodol, never barium, studies should be left for the surgeon, to avoid necessity for duplicate procedures and possible spill of lipiodol into the lungs. Though relatively rare, this condition is usually easily recognized, and every physician privileged to see treatment carried out successfully in such a case has a most satisfying experience (fig. 3).

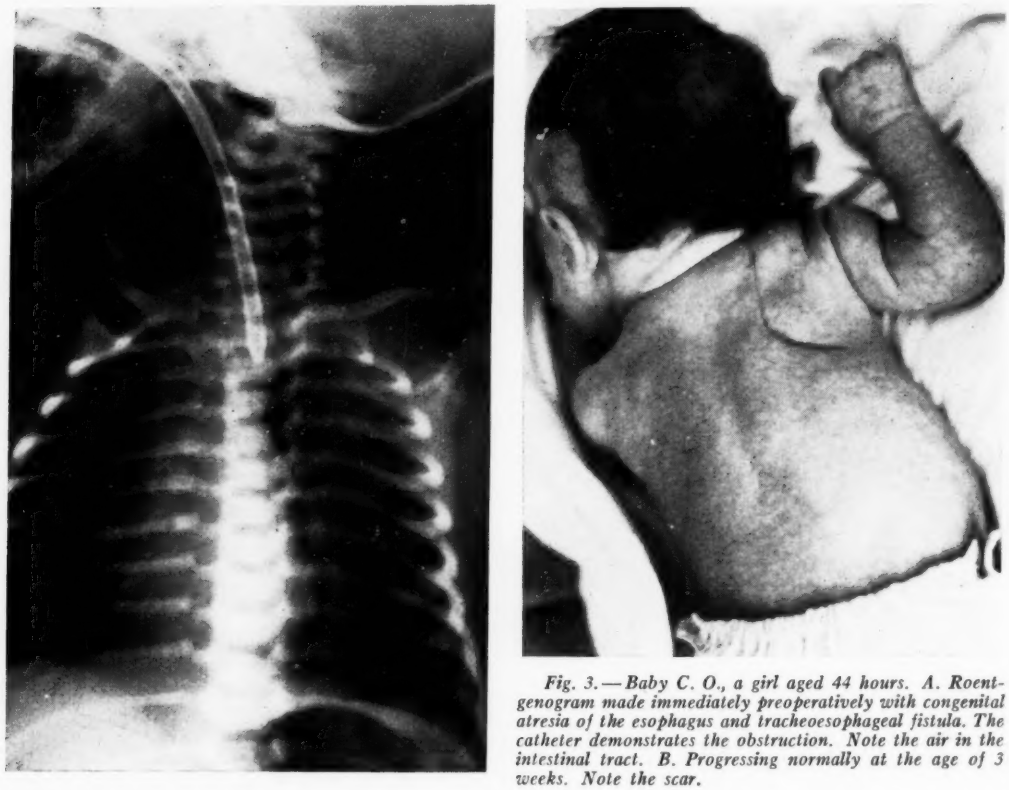

Fig. 3.—Baby C. O., a girl aged 44 hours. A. Roentgenogram made immediately preoperatively with congenital atresia of the esophagus and tracheoesophageal fistula. The catheter demonstrates the obstruction. Note the air in the intestinal tract. B. Progressing normally at the age of 3 weeks. Note the scar.

Surgery of the Chest Wall

A number of years ago the foregoing title would undoubtedly signify thoracoplasty and various methods of drainage of empyema. We believe that it is within the limits and scope of this paper to skip past these well understood and still useful procedures to discuss the increasing number of benign and malignant tumors of the chest wall coming to the attention of thoracic surgeons. These are chiefly chondroma, osteochondroma and chondrosarcoma. It is our conclusion after observing a number of unfortunate results of expectant treatment that, probably, the long present, clinically benign, tumor of this type should be viewed with concern, whether growing or not. That it begins to grow and pursue a malignant course has been demonstrated on a number of occasions in our experience in which a presumably generous biopsy had revealed benign tissue. The development of growth in such a tumor, in our opinion, should be considered evidence of transition into a malignant lesion and constitutes indication for excision with a generous margin of normal tissue. In tumors of this type which have been long present and show no sign of growth, it is nevertheless our intention in the future to recommend resection, for the mortality and morbidity of such a procedure before the mass has attained large size is practically nil and the danger of malignant change is obviated.

Pectus excavatum (funnel chest) is a disabling defect when of moderate severity and is relatively easily corrected in infancy by division of the xiphosternal attachments and substernal ligaments. The pronounced retraction of the lower portion of the sternum when the infant cries is due to the short central tendon of the diaphragm, and, as growth continues, its effect is to draw the sternum dorsally, displacing the heart to the left and embarrassing its function. Another common complication of the condition is a tendency toward repeated pulmonary infections and bronchiectasis. Surgical correction, readily accomplished, with excellent results in infancy, is a formidable but well worth while procedure later, it being necessary at

this stage to resect extensively the deformed cartilages and elevate the sternum temporarily by traction (fig. 4).

Trauma of the Thorax

The severely damaged thorax with multiple broken ribs, abnormal mobility and paradoxic movement on respiration, pneumothorax and hemothorax, and contusion of the lung is a not uncommon problem in this age of speed. There are few conditions that require more of the surgeon's time than these injuries, but, by vigorous treatment with constant attention and checks upon the various specific conditions contributing to the patient's precarious state, in a remarkably high percentage of what formerly were commonly considered hopeless cases the patient may be restored to health. Blood is aspirated from the chest and replaced by transfusion while an intercostal catheter with water seal is used to treat pneumothorax when present. Sucking wounds are, of course, closed promptly and support, but never constriction, is applied to the mobile chest wall.

At times, it has been advantageous in our practice to expose and wire a number of fractures, a procedure which, when applied in the proper cases, causes great betterment, in ability to cough, in respiration, and in relief of pain. As the common cause of death in these cases is the overwhelming retention of bronchial secretions and blood, the energetic, repeated application of catheter suction of the bronchi, with bronchoscopic aspiration as needed, is often the most important aid to recovery. This technic is taught to all residents caring for thoracic surgical patients, and the skill with which they have applied this knowledge has resulted in the survival of a number of patients who otherwise would assuredly have died.

An additional factor of considerable value is the diminution of pain by intercostal block, thereby allowing the patient to cough more effectively. Yet another factor of importance is the realization that the effects of the injury have not reached their maximum as soon as the period of initial shock is corrected. The initial roentgenogram of the chest taken immediately upon admission to the hospital frequently shows minimal changes and should be looked upon as a base line for further study. Later roentgenograms may show the development of the

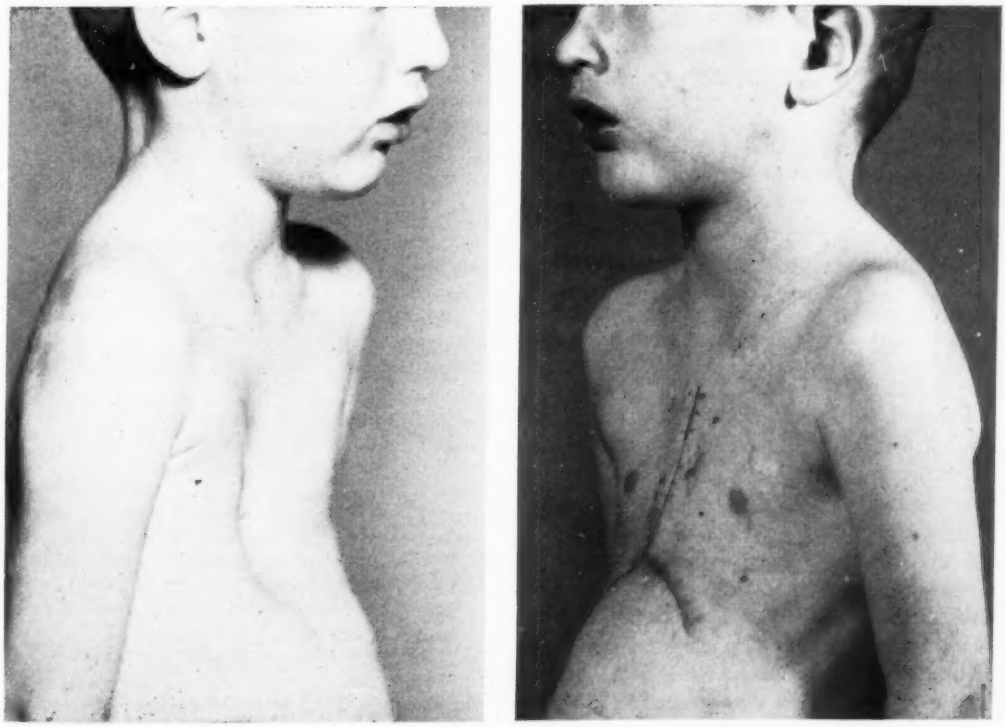

Fig. 4.— R. G., a boy aged 5. A. Severe funnel chest producing dyspnea and cardiac murmur due to mediastinal distortion. B. Surgical correction by an extensive chondrectomy and elevation of the sternum.

serious complications mentioned, and a policy of re-examination daily for about three days is a wise precaution (fig. 5).

Fig. 5. — H. S., a man aged 70. Roentgenogram shows multiple rib fractures reduced and wired for extreme mobility and paradoxic movement of chest wall.

Empyema

This nearly forgotten disease still exists. Antibiotics have successfully cleared empyema when aspirated and irrigated with penicillin, but in most cases eventually drainage is required after reduction in size by the method of aspiration and irrigation. Now, as in the past, the best results are obtained before massive pleural thickening has occurred.

Surgery in Tuberculosis

Along with Graham's contribution to thoracic surgery with his pneumonectomy for carcinoma stands the monumental contribution of Alexander,[8] who modified and remodified the thoracoplasty of Sauerbruch and developed years ago what is basically the modern thoracoplasty of today, making thoracic surgery an important phase in the treatment of pulmonary tuberculosis. Still a tremendously useful procedure, thoracoplasty entails negligible risk, and its results are a high rate of sputum conversion. In recent years, aided by discovery of streptomycin and by improved operative technic, the principle of resection has been applied to tuberculosis in the form of pneumonectomy, lobectomy, and in the past four years, segmental resection. The key to the safety in segmental resection, in addition to correct surgical technic, has been found to lie in the immediate re-expansion of the remaining lung postoperatively. With proper and vigorous postoperative care this procedure has proved safe and remarkably uncomplicated. The preservation of pulmonary functions by the use of this technic has, of course, been its outstanding attribute.

One particular type of tuberculous lesion might be especially stressed for its benignity should always be doubted. This is the solid round or coin lesion, commonly called a tuberculoma. Lesions of this type are frequently tuberculous cavities choked with tuberculous pus and capable of breaking down to produce a spread of the disease. Not uncommonly, however, they are actually early bronchogenic carcinomas. The wisest treatment is biopsy by segmental resection and further resection as indicated, should the gross appearance and frozen section examination reveal malignancy (fig. 6).

Conclusion

Retarded in its development by the complexity of the problem of operating within the open chest, thoracic surgery has now attained a position of great practical application. With the surgery of the other organs of the chest well advanced, it is probable that the last organ to be submitted to direct surgical therapy, the heart, will, within the next few years, become the field of greatly increased and beneficial operations.

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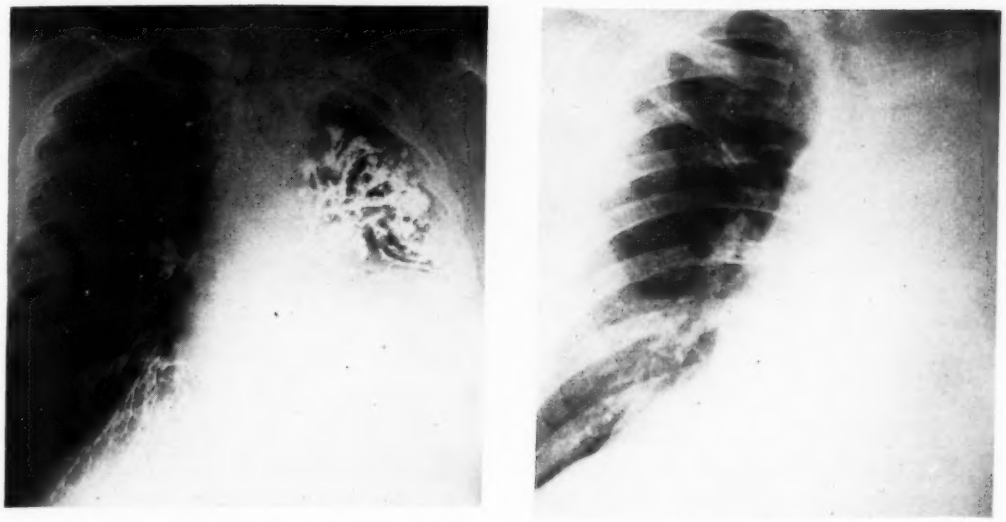

Fig. 6.— H. C., a man aged 40. A. Inactive tuberculosis, left, with extreme secondary bronchiectasis (destroyed lung). B. Postoperative status — free of cough and expectoration after pneumonectomy and concomitant thoracoplasty.

Discussion

Dr. John G. Chesney, Miami: I believe the advances in this field illustrate the importance of medical organization. To go back to the status of surgery of the chest in 1917, toward the close of the war, there was no background for advance in thoracic surgery as there had been in general surgery. Any surgery, it is trite to say, requires a strong background in physiology and pathology and anatomy. When one considers the textbooks and the literature of that day in the field of thoracic physiology, one realizes that it was only basic in its extent and there was little application to clinical thoracic disease. Pathology, gross pathology, was well developed, and microscopic pathology of the chest was well developed, but it was not supplemented with dynamic pathology. Roentgenology was also in its infancy, and the course of thoracic disease was not understood. One need only refer to Gray's Anatomy of those days to see the paucity of material available to the surgeon who might conceivably think of some day removing a lobe or a lung. There was practically no intrapulmonary anatomy described other than the eparterial bronchus.

The world war experience of numerous surgeons, particularly the German surgeon Sauerbruch, gave initial impetus to the development of thoracic surgery. Bulky and unwieldy apparatus occupying half a room for the management of the pneumothorax that would occur during an open thoracotomy was developed. Positive pressure anesthesia, as we know it today, was a long way off. In 1917 a number of surgeons who had operated on the chest met at the instigation of Dr. Howard Lilienthal in New York and formed a small society which eventually became the Society for Thoracic Surgery. For a number of years this society met annually and published its transactions in a portion of a single copy of the Annals of Surgery allotted to it every year. The impetus that was given to thoracic surgery and the study of anatomy and pathology and physiology of the chest by these meetings was tremendous. As a result of their investigation, much of which was animal experimentation, in 1933 Dr. Graham, using reasonable assumptions that had been gained since the war, successfully performed the first pneumonectomy for carcinoma and opened the field of intrapulmonary surgery. I think that there is a great lesson to be learned here, for this medical society, above all, took this field of surgery from a state of nothingness and in the period from about 1920 to 1950 brought it to the point where the variety of procedures performed within the chest rivals in number those performed by the general surgeon.

To go over Dr. Daughtry's summary of the clinical field, there are a few items to which I should like to say amen. I mention first the tracheoesophageal fistula, which I think he covered completely, but which will always bear repeating. Infants in whom this abnormality is diagnosed within the first day or two of life can be taken to the operating room, operated on for three or three and a half hours with anesthesia expertly administered, and closure of the fistula with end to end anastomosis of the esophagus can be carried out without striking ill effects on the baby. The mortality rate has dwindled in many instances to under 20 per cent. This procedure takes the place of the old operation of the construction of skin tubes over the anterior portion of the thorax, a multiple stage procedure that was usually never finished before the child was perhaps 8 years old, if he survived.

The second item is the early correction of the funnel chest. The funnel chest is a most disabling process, which becomes progressively worse as the child develops. It should be corrected early in life, probably preferably under the first year, and such a plan of course demands considerable foresight on the part of the child's doctor because at that time the lesion is not as severe as it will be later. This highly crippling abnormality progresses and requires excessive surgery to correct it at a later date.

Dr. Daughtry, concluding: I thank Dr. Chesney for his remarks.

Experiences with Corticotropin and Cortisone in Pulmonary Disease

JACK REISS, M.D.
AND
GEORGE L. BAUM, M.D.
CORAL GABLES
AND
MAURICE KOVNAT, M.D.
MIAMI BEACH

The discovery and production of pituitary adrenocorticotropic hormone and cortisone have opened a new chapter in therapeutics, if we are to judge by their extensive use in a wide variety of diseased states. The early release of these agents to the profession before adequate clinical experience could be obtained has placed upon it a heavy burden of responsibility for determining the usefulness and dangers of these substances in clinical medicine. These responsibilities stand out in bold relief when one examines the broad spectrum of action of these hormones. Briefly, many of the actions that are known may be considered under several subdivisions:

1. Hemopoietic System: Eosinophils decreased; lymphocytes decreased; platelets increased; polymorphonuclears increased; elevated sedimentation rate decreased; elevated globulin decreased; blood coagulability increased.
2. Kidneys: Renal threshold decrease with tendency to glycosuria and increased clearance of uric acid.
3. Enzymes: Lysozyme altered; all other enzymes decreased.
4. Cellular Structure: Inhibition of toxic action by bacterial ducts, antigens, or chemicals; tuberculin sensitivity inhibited; cell permeability decreased; fibroblastic proliferation checked.
5. Central Nervous System: Pain inhibited; fever reduced; euphoria; change in psyche; psychotic manifestations may occur.
6. Endocrine System: Increased glucogenesis in carbohydrate metabolism; diabetic state may occur; produce adrenal cortical depression.

These widely divergent effects indicate that although corticotropin and cortisone may have a wide field of usefulness, they may also be the cause of dangerous physiologic alterations.

The effects of these hormones on pulmonary diseases have been widely reported.[1-6] Early publications were highly enthusiastic about the results in such conditions as asthma, pneumonia, and even tuberculosis.[1,2,6,8] In later reports,[3-5,7] doubt and skepticism as to the value of these agents have crept in. As yet there appears to be no unanimity of opinion as to the proper place of these agents in the treatment of the various pulmonary diseases. Our contribution towards this goal is a report of our observations in 16 cases. There were 9 cases of bronchial asthma, 2 cases of asthma complicated by extensive pulmonary fibrosis and emphysema, 1 case of interstitial pulmonary fibrosis, 1 case of pulmonary emphysema, 1 case of pulmonary granulomatosis, and 2 cases of severe fulminating pneumonia. The following brief case reports summarize our experiences with the use of these hormones:

Report of Cases

Case 1. — J. H., a 50 year old white man, had had nonseasonal asthma, rheumatoid arthritis and spondylitis for seven years. Little response was obtained with aminophylline, potassium iodide and aerosol therapy over a period of three weeks. Cortisone was given for twelve days for a total dose of 2,000 mg. No change in the clinical picture was observed. Cough and wheezing persisted, and the arthritis was unchanged.

Case 2. — N. C., a 37 year old white woman, had had hay fever for twenty-five years, asthma for one and a

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Chief, Assistant Chief, and Attending Specialist respectively, Chest Service, Pratt General Hospital, Coral Gables.
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half years and periarteritis nodosa. Continuous wheezing, fever, leukocytosis and eosinophilia were present. Muscle biopsy gave negative results. The Thorn test with ACTH produced a 15 per cent fall in circulating eosinophils. ACTH, 80 mg., was given daily, and subsequently the dose was decreased to 10 mg. The patient was treated for eighteen days. She became symptom-free on the fourth day with normal temperature and white blood cell and differential counts. She did not return for follow-up, but reported she was not doing well six months later.

Case 3. — L. S., a 39 year old white man, had suffered from nonseasonal asthma for eighteen years. Frequent repeated attacks were most disabling with only transitory relief on routine therapy. Cortisone, 1,400 mg., was given over a period of two weeks. Excellent results were obtained by the sixth day and maintained on 50 mg. daily. There was considerable gain in weight. The asthma returned one month later and was not relieved on 25 mg. of cortisone daily. The condition gradually worsened into severe status.

Case 4. — S. F., a 29 year old white man with nonseasonal asthma for seven years, was totally disabled by daily attacks. The vital capacity was 56 per cent of normal, and the Thorn test with ACTH gave a 60 per cent drop in eosinophils. ACTH, 80 mg. daily decreasing to 10 mg. over a period of twenty days, was prescribed. Excellent response occurred with the lungs clear by the fourth day. The vital capacity was 112 per cent in the third week. Buffalo obesity, mooning and pigmentation were noted. Three days after the stopping of ACTH, asthma recurred in severe form and was difficult to control. The side reactions disappeared by the third month.

Case 5. — I. D. M., a 25 year old white man with nonseasonal asthma for five years complicated by bronchiectasis, was totally disabled with frequent attacks of status asthmaticus. His vital capacity was 46 per cent of normal. There was a hostility to physicians and nurses on the ward. Cortisone, 1,400 mg. over a period of two weeks, was given with excellent response. The lungs were clear by the eighth day, the vital capacity was 110 per cent at the end of this period, and the emotional outlook was favorable. Maintenance therapy with 25 mg. daily was continued. There was no recurrence after two months.

Case 6. — E. S., a 56 year old white woman, had had hay fever for thirty years and nonseasonal asthma for ten years with almost daily episodes of severe asthma. Cortisone, 200 mg. daily, was given at the start and reduced to 12 mg. orally every other day for two weeks. There was prompt sustained relief with occasional mild asthmatic episodes on maintenance therapy.

Case 7. — G. M., a 23 year old white woman, had had seasonal winter asthma for four years. The severe recurrent episodes responded poorly to routine therapy. Cortisone was given for three weeks. There was a prompt remission, but relapse occurred despite increase of the maintenance dose up to 50 mg. daily. ACTH was substituted with better results with only mild asthma for four months on a maintenance dose of 10 to 15 mg. daily or every other day.

Case 8. — P. G., a 22 year old white woman, had suffered from nonseasonal asthma since childhood. The severe episodes responded poorly to routine therapy with frequent bouts of status asthmaticus. Treatment was started with cortisone, 200 mg. daily. A total dose of 2,600 mg. over a six weeks' period was given. There was a good remission for six weeks on 25 mg. of cortisone as a maintenance dose. The asthma then gradually worsened despite increase of the cortisone to 100 mg. daily, ending in severe status asthmaticus and exfoliative dermatitis.

Case 9. — D. F., a 58 year old white woman, complained of nonseasonal asthma and chronic bronchitis with pulmonary emphysema of twenty years' duration. She suffered severe episodes of chronic asthma with periods of remission in warmer weather. Cortisone was given for two weeks, total dose 2,000 mg. There was only slight improvement, and ACTH was substituted, 1,000 mg. being given over the following two weeks. There was moderately good response, but cough and expectoration continued. The asthma was held in check for two months, but then recurred although it was not as severe as were the previous frequent attacks.

Case 10. — W. W., a 60 year old white man with old healed tuberculosis and bronchial asthma for the past fifteen years, had in the past four months experienced pronounced dyspnea in addition to the severe asthma. The Thorn test gave a 60 per cent drop in eosinophils. ACTH, 80 mg. daily, was prescribed, then reduced to 10 mg. after the fourth day. There was great subjective improvement, euphoria and reduction of the cough and expectoration. Pigmentation occurred together with gain in weight. The remission lasted six weeks. Symptoms recurred with the onset of cold weather.

Case 11. — G. F., a 50 year old white woman of psychopathic personality who had had infectious asthma for the past twenty years was admitted to the hospital in severe respiratory distress. Cortisone, 200 mg. daily for two days, was prescribed. There was no effect on the asthma. There was a pronounced hostile reaction, necessitating transfer of the patient to a mental institution.

Case 12. — M. E., a 58 year old white man with interstitial pulmonary fibrosis and cor pulmonale of eleven years' duration, experienced increasing cough and dyspnea. Roentgen examination showed diffuse parenchymal mottling. Routine treatment for cor pulmonale was ineffectual. Cortisone, 1,300 mg. over a period of two weeks, was given with prompt and excellent subjective relief of the symptoms. A maintenance dose of 50 mg. every other day was continued for two more weeks. Roentgenograms showed no change. The patient was transferred to another hospital for continuation of treatment, but cortisone was not continued there, and the patient had a recurrence of his initial symptoms.

Case 13. — C. K., a 49 year old white man who had had pulmonary emphysema and cor pulmonale over a period of twenty years, showed little improvement on digitalis, vasodilators, salt-free diet and diuretics. ACTH, 60 mg., was given daily for five days with no improvement in pulmonary function. The patient died two weeks later of a myocardial infarction.

Case 14. — L. H., a 24 year old white man, was admitted to the hospital with consolidation of the right lung. The onset was with pleurisy, and anaerobic streptococci were obtained on culture from the sputum. The patient was acutely ill with cyanosis, tachypnea and fever of 104 F. An initial pleural tap failed to yield any fluid. In addition to penicillin, streptomycin and aureomycin, the patient was given 1,000 mg. of cortisone over a period of five days. Improvement occurred on the fourth day of this treatment with reduction in fever and toxicity, but this continued even after the withdrawal of the cortisone. Empyema developed on the tenth day, necessitating thoracotomy on the twentieth day with good recovery.

Case 15. — H. M., a 37 year old white man, was admitted to the hospital with alcoholic hallucinosis and signs of acute suppurative disease of the lung. He was highly toxic, febrile and in a critical state. In addition to routine antibiotic therapy, he was started on 200 mg. of cortisone daily on the third day of his admission, and this therapy was continued for six days. His condition continued unchanged for one week, following which there occurred a gradual defervescence and clearing of the hallucinosis. The entire pulmonary condition cleared after four weeks.

Case 16. — H. S., a 54 year old white man, experienced an illness which was diagnosed as pulmonary granulomatosis of undetermined etiology and ran a febrile course of several months' duration. Roentgenograms revealed extensive involvement of both lung fields. There were severe cough and expectoration, dyspnea, and elevated white blood cell count and sedimentation rate. He received 1,200 mg. of ACTH over a three weeks' period, then 75 mg. of cortisone daily for one week, subsequently reduced to 25 mg. There was a subjective decrease in cough and expectoration while on this therapy, but the patient complained of insomnia, restlessness, loss of libido and skin bronzing. With withdrawal of therapy there was recurrence of symptoms. There was little change in the roentgen picture.

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Discussion

Classifying the results as immediate and late enabled us better to evaluate the effects of these agents. Nine of the patients showed a good initial response as noted by a prompt improvement in the clinical picture. In case 2 the lack of correlation between the eosinophil response, as determined by the Thorn test,[9] and the clinical course should be noted. This has been commented on by others.[10] Eight of these patients were asthmatic, and the other had interstitial pulmonary fibrosis. Of the total of 16 patients, 7 showed no response. Three of these were asthmatic. The other 4 included 2 patients with severe fulminating pneumonia, complicated by abscess in 1 and empyema in the other, both improving slowly under the influence of antibiotic therapy; 1 patient with pulmonary emphysema; and 1 with pulmonary granulomatosis, who showed temporary subjective improvement, but the therapy must also be considered a failure as regards the change in the underlying pulmonary disease.

A follow-up of the 9 patients who showed an initial favorable response revealed even more discouraging results. In only 3 was the remission sustained during this period of observation. One was followed for two months and then lost sight of. Two are free of severe symptoms as long as they continue the use of the drug. One employs 25 mg. of cortisone and the other 10 mg. of pituitary adrenocorticotropic hormone daily (cases 5 and 7). Stopping treatment for a few days results in a recurrence of severe asthma. They have been on this regimen for approximately four months. Six of the initially improved patients suffered relapse within three days to two months after discontinuing the hormones. In 2 of these the rebound of symptoms appeared to be more intense than the original attack. An attempt to procure a second remission in some of these by reinstituting therapy proved futile.

Added to the uncertain therapeutic responses were troublesome and often alarming side reactions. These included insomnia, restlessness, suppression of libido, edema, mooning and buffalo obesity, excessive pigmentation and bronzing of the skin, and a psychotic episode. Four sequelae, coronary occlusion, severe exfoliative dermatitis, empyema, and pulmonary abscess, may not have been related to the hormone therapy employed, but in view of our incomplete knowledge of these agents, they justify mention. Shick, Baggenstoss and Polley[11] reported occlusive phenomena on autopsy material in cases treated with these agents, and the tendency of these drugs to interfere in some manner with the natural containment of infections by body defense mechanisms is well known. The withdrawal of these agents is no guarantee that the side reactions will subside promptly. We suspect that in 3 of our cases, 7, 8, and 16, they became intensified. The extreme bronzing noted in 2 cases, 8 and 16, appeared in patients previously tanned by the sun, and became progressively deeper despite the fact that they were removed from further exposure and the drug was gradually discontinued.

The exact mechanism of action of these hormones in diseased states is still uncertain. Their effect in asthma does not appear to be due to a blockage of histamine.[12] In infectious processes there seems to be also a central action, as noted by a sense of well-being and a reduction of fever without a concomitant change in the local process. But simple relief of pain, reduction of the febrile course, and the production of euphoria are not good therapy if the morphologic state remains unaltered. Hench, Kendall, Slocumb and Polley[13] stated that in no condition is the etiologic agent influenced by these hormones. It is only the tissue reaction that is affected. When these tissue changes are harmful and disabling, their correction may favorably influence the diseased state. When they are necessary for the natural healing processes or the containment of noxious agents, their elimination may prove harmful. Absence of phagocytosis and inhibition of fibroblastic response may result in deleterious effects on the disease process.

Summary and Conclusions

Sixteen patients with various pulmonary lesions were treated with pituitary adrenocorticotropic hormone and cortisone. Relief of symptoms was obtained in 9, or slightly more than 50 per cent, but the majority of these experienced relapse in a comparatively short period of time. In chronic and recurrent pulmonary conditions such as asthma, temporary relief may often be obtained with these hormones, but the rebound of symptoms is so common that one should exhaust every avenue of conventional treatment before resorting to these drugs. For severe acute pulmonary conditions with grave prognostic signs, when accepted therapy has failed, these agents may be employed with caution. But even here their use is warranted only on the basis of clinical research and a realization of their pro-

found effects and dangers. Until further studies reveal more fully the mechanism of their action, the cause of resistance to their prolonged use, and the means of avoiding or counteracting the undesirable side reactions, we must consider them unsuitable for the routine treatment of pulmonary diseases.

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311 Lincoln Road, Miami Beach.

The Fragile Male

Wilson T. Sowder, M.D.
JACKSONVILLE

Physicians and laymen alike are familiar with the fact that the present life expectancy at birth for females is considerably greater than that for males, the latest figures being 64.7 years and 70.2 years respectively. Many of us have ascribed this to the fact that deaths more often affect males, as a result of military action, accidents and homicides, and have not realized that the matter goes much deeper. According to the National Office of Vital Statistics there has been a considerable difference in mortality between the sexes at least since 1900; and since World War I the differential in the death rate between males and females has become progressively greater. For example, in 1926 the age adjusted death rate for males was a little more than 14 per cent higher than that for females, whereas by 1948 the difference had increased to 41 per cent. The death rate for females in the United States decreased 13 per cent from 1940 to 1949 while the death rate for males decreased only 7 per cent. According to mortality figures for the United States for the year 1949, these sex differences in mortality are apparent and definite in every age group. For instance, in 1949 the death rate for infants under 1 year of age was 38.3 per 1,000 for males and 29.5 per 1,000 for females, the male death rate being 30 per cent higher than that for females. At the other end of the age scale, the death rate for males 75 years of age and over was 123.8 as compared to 104.2 for females. Also, it appears that the greater weakness of the male appears even before birth since in 1949 there were 10,353 deaths from congenital malformations amongst males as compared to 8,339 among females. In order to show the breadth of the problem the number of deaths by sex from several major disease conditions is given in table 1.

Similar figures are shown for Florida in 1949. Of 643 deaths occurring from tuberculosis, 424 occurred in males and 219 in females. Of 13 deaths occurring from poliomyelitis, 10 were in males. Of a total of 25,317 deaths occurring in 1949, 14,974, or about 60 per cent, occurred in males. One naturally wonders, if males die at a greater rate, why there is not a greater inequality in the sex distribution of the population. The fact that there is at present no great inequality in so far as the total population is concerned is shown

State Health Officer.

by the fact that the population of the United States (United States Bureau of the Census estimate) as of July 1, 1948 was 146,571,000 of whom 72,969,000 were male and 73,602,000 were female. One would expect that with such a differential in mortality there would be a vast difference in the number of female survivors in the older age groups. Of an estimated population of 446,000, 85 years of age and over in 1948, 191,000 were male and 255,000 were female. Nature in some subtle manner seems to arrange for a fairly equal distribution of the sexes by causing more male babies to be born.

In Florida for instance, in 1949 there were 106.2 male births per 100 female births. It is interesting also to note that there were 108.0 white male births per 100 white female births, as compared to 101.9 Negro male births per 100 Negro female births. Incidentally, the differential between male and female mortality in the Negro population in the United States is less pronounced than in the white population. Although males are born in greater numbers, their higher death rate brings the two sexes to about equal numbers at around age 20, and thereafter females are in the majority. Females have a substantially greater mortality rate from diabetes and about the same death rate from cancer. Deaths incident to childbirth have become almost negligible in the over-all picture in the United States and in Florida in recent years. In 1950 only 83 deaths from this cause occurred in Florida out of a total of 26,533 deaths. Since deaths incident to childbirth are becoming progressively more rare, and deaths from diabetes are preventable in a large proportion of cases, and since the major types of cancer causing death among women are those of the breast and cervix which are more susceptible to treatment than other types of cancer, it appears that the outlook for further decreases in mortality is more favorable for the female than for the male.

Every practicing physician should give considerable thought to this problem. Much special effort in the past has been devoted to the care and treatment of women. The time has arrived for the medical profession to investigate the problem and determine whether or not more attention should not be paid to the health of the weaker of the sexes.

1217 Pearl Street.

Table 1.—Deaths from Specified Causes in the United States, 1949

Cause of Death	Both Sexes	Male	Female
All causes	1,446,000	824,220	621,780
Tuberculosis (all forms)	39,032	25,483	13,549
Syphilis and its sequelae	8,236	6,179	2,057
Acute poliomyelitis	2,074	1,261	813
Malignant neoplasms, including neoplasms of lymphatic and hematopoietic tissues	204,651	102,671	101,980
Diabetes mellitus	24,488	9,671	14,817
Major cardiovascular-renal diseases	746,854	420,544	326,310
Pneumonia and influenza	40,042	22,738	17,304
Ulcer of stomach and duodenum	8,020	6,540	1,480
Appendicitis	3,792	2,304	1,488
Hyperplasia of prostate	6,027	6,027	....
Complications of pregnancy, childbirth and the puerperium	2,954	....	2,954
Congenital malformations	18,692	10,353	8,339
Birth injuries	12,320	7,164	5,156
Postnatal asphyxia and atelectasis	12,301	7,521	4,780
Immaturity	24,480	13,802	10,678
All accidents	88,681	61,820	26,861
Suicide	17,125	13,258	3,867
Homicide	8,812	6,686	2,126

Note: Deaths from specified causes do not equal deaths from all causes because of the omission of some categories from the table.

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Epidemiologic Importance of Man's Transportation of Mosquito Vectors of Malaria

J. Basil Hall, M.D.
MOUNT DORA

Mosquitoes, by the hundreds, come to Florida from South of the Border yearly. These potential malaria and other disease-carrying pests come in "on the wing," but fortunately for us they are riding the airliners, and most of them are dead when landed.

Their presence is nothing new, since mosquitoes have probably plagued man throughout his entire existence. Fossil specimens indicate that there were Culex species on earth before man made his appearance here.[1] The intermittent fevers, considered by many to be malaria, are among the oldest recorded diseases.[2] Chinese mythology described three demons, assigning to the first a hammer, to the second a pail of cold water, and to the third a stove. These supposedly represented the headache, the chill, and the fever.[3]

The Greeks and the Romans, during the time of Christ, showed some understanding of the epidemiology of the disease and speculated as to its etiology. Varo (118-29 B.C.) even referred to the little animals that were invisible to the eye, were borne by the air, and would cause disease that one could get rid of only with difficulty. The Hindu Susruta, in the fifth century A.D., attributed the spread of a disease to the mosquito and gave a fair description of malaria.[3,4]

Yet, during the next 1,500 years little knowledge was gained regarding this disease, although it was relatively widespread throughout the civilized world. Hence it is difficult to evaluate the part man's transportation of the malaria vector has played in world history since the fall of ancient Greece to its present attack on modern India. Some think that the welfare of Greece was undermined by it.[1]

The possibility of transporting the malaria vector, as such, was not recognized early.[1] In fact, not until Ross and the Italians performed their classical work did the mosquito control phase get any more attention than was necessary to minimize these insects as a public and personal nuisance. The epidemiologic importance and the public health implications simply had not been appreciated.[5] The earliest recorded instance in which a mosquito vector of malaria was transported by man was an experiment. In 1900, infected mosquitoes were sent from the Roman Campagna to London; two subjects were bitten by these mosquitoes and became ill in "due time" with malaria.[6]

Ross,[2] in retrospect, referred to outbreaks of malaria that occurred in 1866 and 1867. He described the islands of Mauritius (550 miles east of Madagascar) and Reunion, separated by 125 miles of water. He stated that on both islands there was a severe epidemic. Epidemic malaria had been unknown prior to 1865. The outbreaks occurred simultaneously in the two islands. He and others expressed the opinion that these were the result of Anopheles gambiae having been introduced by a boat from Africa or elsewhere one or two years prior to the outbreak.[1,7]

Herms and Gray[5] stated that the problem of transporting mosquitoes has been present for hundreds of years, and the following quotation is indicative of the part transportation could have played. These were the posted regulations regarding steamer traffic on the Nile River in 1903.

> ". . . . 3. The thing to be avoided is returning to Khartoum with mosquitoes on board. If this is done, wells and water collections in the town which have been cleared at trouble and expense are liable to become reinfected. This has happened repeatedly, so that it is very important that steamers should arrive clean and free. It is well to have all bilge water emptied on arrival and all steamers lying up should be inspected and treated in the manner described. Similar precautions are required as regards barges, launches and any vessel on which there is stagnant water. Note — It has been proved that mosquitoes, as a rule, will not stay for any length of time on a steamer if they are prevented from breeding out on board. Consequently, such preventive methods are effective, as has been demonstrated on several occasions; and there is no excuse in most instances, for steamers reaching Khartoum with their bilge water, etc., full of larvae and pupae, and their cabins full of adult mosquitoes."[2]

It was stated that these regulations were put into effect after species of Anopheles were found to be breeding on the boats plying the Nile.

For the same year, 1903, Grubbs,[7] Past Assistant Surgeon, United States Public Health and Marine-Hospital Service, presented interesting data concerning the transportation of mosquitoes by ships. He listed the findings on 82 vessels inspected at the Gulf of Mexico Quarantine Station. Five ships admitted having mosquitoes at port of departure, two getting rid of them when well at sea, and three carrying them for only two days. Four of the five had no further trouble, but the fifth, a schooner, again had an abundant supply when shore was reached and after several days at sea. Nine of the vessels had no mosquitoes on departure (so the captain stated), but had them appear at sea. Grubbs[7] recounted that on one ship he was met by a constant "buzzing" in the forecastle, and all who entered were attacked by many mosquitoes.

All of this was happening in the twentieth century and after years of a form of quarantine practice. Quarantine was being applied during Biblical times, and Venice was operating a Maritime Quarantine Station in 1403, almost a century before America was discovered. Our present quarantine law was enacted in 1893 and extended to cover aircraft in 1926.

In 1904, 2 male and 129 female mosquitoes of the Anopheles albimanus species were taken at Key West, Florida.[8] MacDonald, the investigator, thought all of these to be the progeny of a single female, possibly transported by a vessel from Vera Cruz, Mexico. Further, he believed that he completely exterminated the breed, thus preventing a successful invasion by the West Indies' chief malaria vector. Single specimens, however, have been taken at intervals since that time.[8,9,10]

The first commercial airplane flight to the United States from a port outside the continent was made in 1927 from Havana, Cuba to Key West, Florida.[11] It was realized early that air transportation presented an entomologic threat of public health significance. There are approximately 290 recognized species and varieties of Anopheles alone, not more than 12 of these occurring in the United States and Canada;[9] 62 others belong to our Southern neighbors and 22 to Europe and North Africa. South Africa has 85 species with 109 listed in Asia, the Philippines, and the Australian region. Fifty-four of the 290 total are regarded as important vectors somewhere within their range. Only 3 of these are found in the United States at the present time.

The epidemiologic possibilities[5] of man's transporting of the mosquito vectors are:

1. The introduction of a new and more efficient vector into an infected area.
2. The introduction of an infected vector into an area where vectors do not exist.
3. The introduction of infected vectors into an area where vectors, free of disease, are in abundance.
4. Increased expenses to states and communities because of the population's high susceptibility,[12] and radical and costly alterations in anti-mosquito measures necessitated by the habits of the newly introduced mosquitoes.

Soper and Wilson[13] in 1943 gave an excellent account of the establishment of the A. gambiae in Natal, Brazil. None of this species were found in this area in 1928 during a rather complete survey in search of Aedes aegypti. Two thousand larvae were collected in Natal in March 1930. The A. gambiae is believed to have crossed the Atlantic late in 1929 or early in 1930 on one of the fast destroyers.[11] The boats made the trip from Africa to Brazil in less than 100 hours. It is thought to have made the trip in the adult form since all the water containers were closed and no larvae on ships were ever found. These ships anchored within 1 kilometer of the shore, which is within easy flight range of this native African vector. Three planes could have been involved, although larvae or adult mosquitoes of this species were not recovered at or near the airport.

This chance introduction cost thousands of lives and an inestimable amount of time and money spent in eradication.[13] If this species has been eradicated, as it now appears, it is the first such case on record and will have a direct influence on the mapping of future fights on malaria.

During the late war, mosquitoes were transported by plane and military convoy into areas not previously inhabited by their species.[3] Cargo vessels from New Guinea and the Philippines, carrying automobile and truck tires, arrived at Los Angeles with live adult mosquitoes in the hold.[14] It is obvious that mosquitoes can easily gain entrance to a new area, and even harmless ones in their native habitat might possibly become vectors of disease in their new environment. The fact remains, however, that malaria-free areas still exist, even though topography and climate appear

ideal and chance introduction is an ever present possibility.[15]

During an eight year period from 1940 through 1947, more than 12,000 mosquitoes were found in aircraft entering the United States. Many of these were collected at Miami's International Airport, and only a small percentage were living when collected.[11] During 1948, 1949, and 1950, only 601 mosquitoes were taken at Miami, and of this total, 445 were dead.[16] So long as known methods of environmental sanitation and the proper spraying of transporting vehicles are utilized effectively, and with constant vigilance, there will be little danger from such importations.[17]

The Foreign Quarantine Service of the United States Public Health Service maintains a year-round service where the hazard of importation and possible implantation of disease-carrying arthropods exists.[11] This service is aware of no record of establishment of a species of mosquitoes or other arthropod vector in the United States or its territories as a result of importation by aircraft.

Florida still presents an ideal habitat for mosquitoes, not only for the malaria vector, but the vectors of yellow fever, dengue, encephalitis, and filariasis as well. The yearly expense of preventing successful entry is small when compared with a single campaign that is necessary when a new species is imported.

Summary

The literature on man's transportation of the mosquito vector of malaria has been reviewed.

One of three criteria must be fulfiled if this transportation is to be considered epidemiologically important:

1. Introduction of a new vector (infected or noninfected) into an area.
2. Introduction of a more efficient vector to an area already infested with infected mosquitoes.
3. Introduction of an infected vector into an area where vectors, free of disease, are in abundance.

The extent played by man's transportation has not been established. The geographic distribution of the mosquito vector of malaria at the time man began his travels is not known. Priority has not been established in many areas as the epidemiologic importance and Public Health implications of the mosquito were not appreciated until near the turn of the twentieth century.

The literature indicates that the mosquito was allowed to travel rather freely on the ocean-going vessels in the early days. Indications are that they have utilized practically every mode of transportation of modern times; yet the actual geographic distribution of the Anopheles mosquito has changed but little during the past fifty years.

The possible eradication of the A. albimanus in Key West, Florida and the A. gambiae in Brazil was reported.

The epidemic in Brazil was reported as having resulted from man's importation by boat of a more efficient vector while the explosive outbreaks in Mauritius and Reunion probably resulted from the importation by boat of an infected vector.

Numerous importations by planes were listed. No evidence was presented, however, that would indicate the establishment of a new species as a result.

Though importation and successful implantation are more potential than acute, it is prerequisite that man be continually on guard against the possibility of transporting Anopheles into such areas as New Caledonia and Hawaii. Neither does he want to import the Anopheles darlingi to Africa, the salt water Anopheles sundaicus to the Philippines, nor A. gambiae again to the new world.

Importation in the early instances may be charged to ignorance, but the literature cited indicates that man now has the knowledge and equipment to rid the transporting vehicle of disease-bearing vectors. Henceforth, it can, perhaps, be charged to neglect.

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97 Lake Shore Drive

A Technic for Early Postoperative Care of "Wet Colostomies"

MAX SUTER, M.D.
JACKSONVILLE

With the advent of the pelvic evisceration for carcinoma of the cervix advocated by Alexander Brunschwig, the "wet colostomy" has presented an increasing problem. The late care of the "wet colostomy" has been satisfactorily handled by the use of the Rutzen bag, which is sealed to the skin by a special cement. The early postoperative care has been particularly difficult because of the constant urinary and fecal contamination of the fresh wound.

The following procedure has been used to facilitate the early postoperative care of patients subjected to this operation: Catheters large enough to fit snugly are placed in the ureters after the ureters are separated from the bladder and fastened with a circular tie close to the distal end. The ureterocolostomies are performed in the usual manner with the distal ends of the catheters placed within the large bowel. After the colostomy has been completed, the bowel is opened, and the catheters are "fished" out and securely anchored to the skin dressing so that no pull can be exerted on the ureters. Each individual catheter is connected to a drainage bottle. Although only rubber catheters have been used up to the present time, these have been left in place for over two weeks without difficulty. The use of less irritating substances like polyethylene tubing may permit the retention of these catheters for longer periods of time. The catheters are simply pulled out in order to remove them.

The suggested method of handling the ureters in "wet colostomies" offers the following advantages:

1. It permits the wound to stay dry until healing of the wound has occurred, and it is then possible to use a Rutzen bag.
2. The ureters are kept open, and adequate drainage to the kidneys is assured.
3. Reabsorption of waste products in the large bowel is prevented in the early postoperative period.
4. It is possible to check urinary function from the individual kidneys.
5. Ascending infections in the ureters are minimized until the patient convalesces from the operation.

Summary

A technic for the handling of ureters in "wet colostomies" is reported.

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2720 Park Street.

From the Gynecologic Service of the Duval Medical Center.

From Our President

American Medical Education Foundation

There are probably very few members of the medical profession who are not aware of the financial plight of the medical schools of this country. Inflation, with its accompanying increased operating costs and decreased revenues, is the obvious cause.

As always, the Federal Government has the answer, subsidization. A recent ruling of the United States Supreme Court holds that what the government subsidizes, it also controls. Should the medical educational system of this country fall under Federal control, a great wedge toward socializing the medical facilities would have been established. It is hard to believe that the Federal Government would be any more successful in its operation of the medical schools than in its other activities. A deterioration in the quality of the medical profession would be inevitable.

The chaotic condition of medical education in this country, in the middle of the last century, was largely responsible for the founding of the American Medical Association. Its interest in medical education was the motivating factor of this organization for the first fifty years of its existence, and has resulted in the highest standard of training in this field the world has ever known. The success of this endeavor is reflected in the health of our citizens. This is the healthiest large nation in the world.

The American Medical Association has remained keenly interested in medical education and has proposed a two point program for meeting the present crisis. First, the American Medical Association proposes one time Federal grants for renovation of existing facilities and construction of new physical plants.

These funds are to be administered locally and would be relatively free of the danger of Federal control. Such a grant will solve the largest financial difficulty.

Second, the American Medical Association proposes the increased contributions from private sources for operating expenses.

The American Medical Association organized in December, 1950, the American Medical Education Foundation to carry out this program. This Foundation has requested of each of the physicians of this country, $100. Such a contribution would annually yield approximately $18,000,000. In addition to aiding in operating the schools, it is hoped that the response on the part of the profession will stimulate lay contributions. Under our present economic condition and the present tax program, philanthropic endeavors must of necessity have a broader base than previously, i.e., many small contributors must participate in contrast to the single philanthropist of the past.

The monies collected by the American Medical Education Foundation will be distributed to the medical schools to be used as needed. The American Medical Association has assumed the cost of operating the Foundation, so that all money collected would be used for the purpose to which it was donated. The contributor may designate the school to which his contribution is to be given, if he so desires. The United States Commissioner of Internal Revenue has ruled that these contributions are exempt from taxation.

It is understandable that many doctors in Florida will be unable to donate $100, but each can give something. The Medical Education and Hospital Committee of the Florida Medical Association has the special assignment to urge gifts. Each component County Medical Society has a committee with a similar purpose.

If you are wondering why you should contribute, remember that someone else paid for your medical education; your tuition and fess were entirely inadequate. If you attended a tax supported institution, the tax payers of that State assisted you. If you were educated in one of the endowed schools, the supporting foundation supplied the deficit.

Florida can not look with pride on its medical educational facilities, but with your help it can lead in the support of the American Medical Education Foundation.

David R. Murphy Jr

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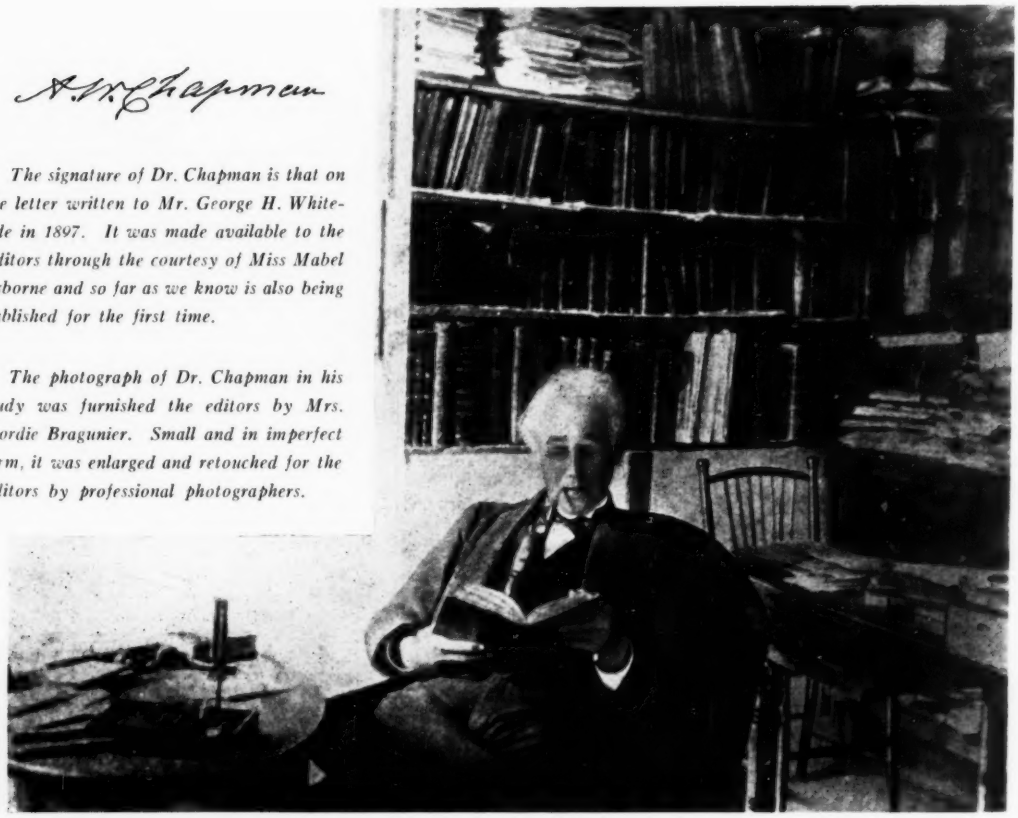


The signature of Dr. Chapman is that on the letter written to Mr. George H. Whiteside in 1897. It was made available to the Editors through the courtesy of Miss Mabel Osborne and so far as we know is also being published for the first time.

The photograph of Dr. Chapman in his study was furnished the editors by Mrs. Mordie Bragunier. Small and in imperfect form, it was enlarged and retouched for the Editors by professional photographers.

Famous Florida Physicians: Gorrie and Chapman

In the thriving little seaport of Apalachicola, the third largest cotton market on the Gulf Coast, a young physician named John Gorrie arrived in 1833. About the same time, another young physician settled in West Florida. He chose Quincy for his home, later moved to Marianna and then in early January 1846 he, too, settled in Florida's principal commercial town, Apalachicola. The name of this second young physician was Alvan Wentworth Chapman. Around his remarkable life story notable events in Florida revolved for more than half a century.

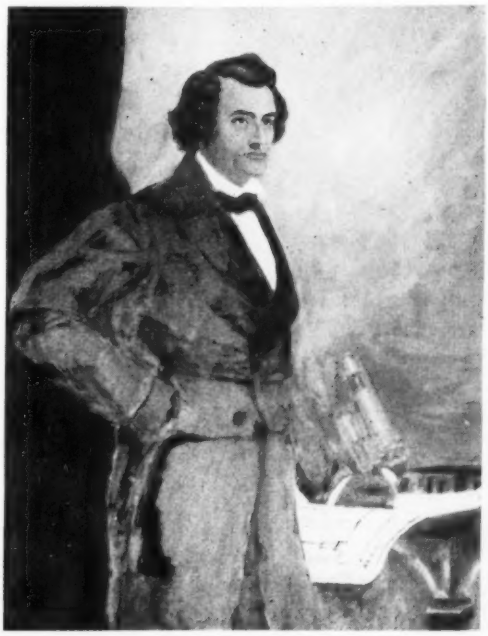
Born at Southampton, Mass., on Sept. 28, 1809, Dr. Chapman died at his home in Apalachicola on April 6, 1899, in his ninetieth year. The son of Paul and Ruth Pomeroy Chapman, he entered Amherst College at the age of 17, graduating with honor four years later. From 1831 to 1833 he was the tutor of a family on Whitemarsh Island, near Savannah, Ga., and in 1833 he was elected principal of the academy at Washington, Ga. It was there that he began the study of medicine, and upon moving to Florida in the winter of 1834-1835, he began the practice of medicine, which he continued for more than half a century.

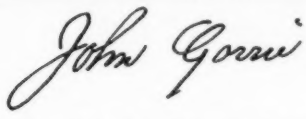
Dr. Chapman had received no formal training in botany, but his interest therein began before he left New England. Soon after his arrival in Florida, he began sending specimens of Southern plants to Dr. John Torrey, distinguished New York botanist, and his famous pupil, Dr. Asa Gray. His first letter to Dr. Torrey was dated Gadsden County, Jan. 12, 1835. In 1838 the genus Chapmania was named in his honor. The semitropical and tropical vegetation of Florida so fired Dr. Chapman's mind that he became its pioneer investigator. In 1843, his quest led him as far south as Key West. He became the foremost authority on "Flora of the Southern United States." His book bearing that title was published in 1860 and republished in two later editions. For nearly fifty years it was the only manual of the flowering plants of the Southeastern states.

Dr. Chapman was a handsome man. He was about 6 feet tall, and his hair was of that fine texture which is likened to snow. His eyes were clear and blue. He usually wore dark blue suits, was dignified in his movements and walked slowly with head slightly forward, a habit acquired from searching the ground for flowers. He was deaf, but his sight was remarkably good with one exception. He was color-blind. After Dr. Gray had visited him, Dr. Chapman wrote:

> I had . . . found a new Rhododendron in bloom. . . . Fortunately he came early enough to catch the pretty witch in bloom. . . . It always looked white to me but Gray said it "blushed pink." . . . "You are right," he said. "I never saw this species. I congratulate you on Rhododendron Chapmanii."

Dr. Chapman could not detect the color red in any of its shades. Blue was clear and natural, but a red rose to him looked dull brown.





This picture of Dr. Gorrie is a reproduction of a portrait by Charles Foster.
The signature of Dr. Gorrie, executed in 1837, is being published perhaps for the first time.

In 1839, Dr. Chapman married Mrs. Mary Ann Hancock of New Bern, N. C. During the War Between the States she went to her former home in Marianna. He is quoted as saying:

> I was a Union man . . . and right there my wife and I disagreed. . . . We agreed to part. . . .I never saw her during those . . . stirring years [of the war].

Dr. Gorrie having died in 1855, Dr. Chapman was the only physician in Apalachicola during the war. That fact may have saved his life, for his

services were in demand even by his enemies. He said that many times he would not have given sixpence for his life.

After the war he began to devote more time to botany and less to medicine. Later he humorously said:

> . . . there is a lot of pother in this doctoring; and I find that my deafness is not entirely detrimental, since if I can't hear people's groans they won't send for me. My flowers are far more satisfactory. . . .

In 1886, the University of North Carolina conferred the LL.D degree upon him.

In February 1897, about two years before his death, Dr. Chapman wrote a letter to Mr. George H. Whiteside in reply to his request that Dr. Chapman give him personal information about Dr. Gorrie. Mr. Whiteside's first article published in "Ice and Refrigeration," in May 1897, and subsequent articles by him have been quoted many times.

Dr. Gorrie's life has become much better known than that of Dr. Chapman. Nevertheless, although Dr. Gorrie was the first to produce artificial ice and the father of air conditioning, not until recently, could even a short biography of Dr. Gorrie be found in the Encyclopaedia Britannica. To Mr. Whiteside; to the Southern Ice Exchange, which erected a monument to Dr. Gorrie in Apalachicola in 1900; to Col. G. N. Saussy, who first advocated the placing of Dr. Gorrie's statue (1907) in the national Hall of Fame; to Drs. Edward Jelks and H. Marshall Taylor of Jacksonville, who published articles on Dr. Gorrie in 1931 and 1935; to Miss Mabel Osborne of Apalachicola and Mrs. Laural Hobbes of Jacksonville, who have unceasingly worked for better recognition of Dr. Gorrie; to Ruth Eugene Mier, who in her Master of Arts thesis at Stetson University in 1938 corrected several errors and added information concerning Dr. Gorrie's life, we owe much.

Quite a bit of the information concerning Dr. Gorrie's life which is available to us today is based on Dr. Chapman's reminiscences. The mystery surrounding Dr. Gorrie's birth and early years in South Carolina perhaps will never be entirely cleared. The famous Mansion House story, which is perhaps the best known and most dramatic incident of Dr. Gorrie's life, probably did not occur in 1850, but perhaps in 1849. The Editors of The Journal have incontrovertible evidence that the large ice cubes were first made in a machine manufactured for Dr. Gorrie, not in New Orleans or Pensacola, but in Cincinnati, Ohio. The time was the fall of 1848. This information will be enlarged upon later, but is given now to show that much more study and research are needed to develop properly the true life story of Drs. Gorrie and Chapman.

Dr. Chapman's integrity and reliability as a historian were of the highest order, but errors in memory with regard to dates and important particulars have necessarily occurred.

Toward the end of his life, Dr. Chapman remained vigorous in both mind and body. Like so many great men, he had a simple creed. It seems to be summed up by the quotation from Coleridge which he adopted as his own:

> He prayeth best who loveth best
> All things both great and small;
> For the dear God who loveth us,
> He made and loveth all.

Within a week of his death, Dr. Chapman walked two or three miles to gather the blossoms of a rare species of the ash tree. On April 6, 1899 he was seized with a heart attack, probably coronary occlusion, the pain of which did not respond to treatment as had previous attacks of pain. In about an hour he died. On his mantel were flowers which had recently arrived at his home, Viburnum desifilorum, locally known as Chapman's honeysuckle.

Those who thought that Dr. Chapman was a stern and haughty man were mistaken. His interest in flowers and plants, their growth, characteristics and beauty, gave him no time for pettiness or small thoughts. He gave himself to his professions and a few friends. To people in general his deafness served as a barrier which afforded him the isolation he loved and enabled him to devote himself assiduously to botany and medicine.

Largest Medical Defense Meeting Held

The success of the Medical Civil Defense Conference held in Chicago in mid-November was declared by a spokesman for its sponsors to be "a real inspiration to all of us in exerting a greater effort for the big job ahead." The attendance of 250 was the largest so far for a medical meeting of this kind. The meeting was sponsored by the American Medical Association, the American Hospital Association and the Association of State and Territorial Health Officers.

Noteworthy is a resolution, unanimously adopted, calling for all medical personnel to be "assigned to their proper places in the local civil defense organization; their assignment to be the responsibility of the legally authorized civil defense officers according to the laws in the various states, and

only after full consultation with the local, state and/or national professional health organizations which exist in the various fields."

The resolution provided further that "the professional and tactical organization and training of individuals and units will be the prime responsibility of legally authorized civil defense officers, again, only after full consultation with local, state and/or national professional health organizations in these fields."

The many speakers, among them Millard F. Caldwell, administrator, Federal Civil Defense Administration, stressed the necessity of coordination between health and welfare planning in developing a well rounded program of disaster relief. It was pointed out that genuine nationwide cooperation between the health officer, the hospital and the medical and allied health personnel—of all categories—is essential to the success of the civil defense movement. One speaker particularly emphasized that the necessity for mobile support, to be fully met, must depend upon health personnel in the remote areas, not in the target areas.

"If there was one central theme," commented Dr. James C. Sargent of Milwaukee, chairman of the A. M. A. Council on National Emergency Medical Service which sparked the meeting, "it seemed to be that now since the preliminary phases of planning, financing and procedure have passed, it is high time to make a positive and concerted effort at recruitment of the hundreds of thousands of American citizens necessary to carry out this gigantic program."

The General Practitioner and Industrial Medical Practice

Increasingly during recent years, responsibility for industrial medical service, particularly illnesses and injuries related to employment, has been accepted by the general practitioner. It has been estimated that he renders as high as 85 to 90 per cent of industrial health services. The report of a survey made by the American Academy of General Practice in May 1950 is therefore of particular interest, for its purpose was to determine the distribution and type of practice of its members.

This survey revealed that 95 per cent of the membership cared for industrial cases. In 1948, such cases averaged 234 per member. Approximately 20 per cent of the membership engages in full time industrial practice.

In view of these significant findings, a joint committee of the Academy of General Practice and the Council on Industrial Health of the American Medical Association, meeting with representatives of the American Medical Association Section on General Practice, agreed upon the desirability of formulating a joint program for the education of general practitioners in the fundamentals of industrial medical practice. The program and curriculum are to be implemented on a national, state and local level through joint cooperative effort of the participating groups.

While the need for development of an industrial health education program geared to the requirements of the general practitioner is not new, it nevertheless takes on added significance in the present national emergency. To meet the health needs of a rapidly expanded work force in war industries during World War II, it was necessary to draw heavily on the services of the general practitioner. Currently, the national defense program makes it necessary again to look to the general practitioner in planning for the health needs of the workers in essential industry. He is privileged to make an important contribution toward the success of the national defense program which depends on effective industrial production. No doubt he will welcome a properly coordinated national program of education designed to orient him for the full discharge of this task.

British Surgeon Reviews Health Plan

Speaking in Chicago recently, Dr. A. Lawrence Abel, president of the London area of the British Medical Association, described himself as "not a politician but merely a humble member of the medical profession working hard at practical surgery in the heart of London." He told the annual convention of the International College of Surgeons that the cost of the National Health Service in England has far exceeded all estimates made before and during the time it took effect four years ago.

"The exchequer has at last realized," said this distinguished representative of the British Medical Association, "that my country cannot afford to make available the unbridled use of such an essential service. Whereas last year the health service cost nearly one billion, five hundred million dollars, they have now imposed an arbitrary ceiling of under one billion, two hundred million dollars . . . and a few weeks ago ordered that 50 per cent

of the cost of dentures and spectacles should be paid for by the patient."

Despite the huge cost, Dr. Abel made the surprising statement that out of the weekly contribution to national insurance the family doctor receives less than three cents. He remarked that in England twenty cigarettes cost 49 cents, each cigarette costing 2½ cents, and then observed, "The family doctor, therefore, out of the contribution receives the equivalent of approximately one cigarette a week!"

So far as he could recall, not a single promise made by the politicians to both doctors and patients has been kept. He painted a depressing picture as he recited the pitfalls of this vicious system. They are the same pitfalls strewn in the path of the medical profession in this country by vote-conscious politicians in their efforts to enact some form of compulsory health insurance. As in England, they promise the sky, knowing only too well from British experience that they cannot deliver.

Graduate Medical Education

The Department of Medicine of the Graduate School of the University of Florida through the Committee on Medical Postgraduate Course of the Florida Medical Association announces its schedule of graduate courses offered for the first six months of 1952.

The Midwinter Seminar in Ophthalmology and Otolaryngology was held the week of January 14-19 in Miami Beach. This was the sixth annual presentation of this specialized course. Each session has been well attended and has offered the best in this field.

The Seminar on Diabetes, lasting two days, will be presented the latter part of March or the first part of April in West Palm Beach. The date will be announced in the March issue of The Journal, and notices will be sent to the various county societies throughout the state as soon as the exact date and speakers are ascertained.

On June 19-21, a Seminar on Diagnosis will be held at the George Washington Hotel in Jacksonville. The tentative outline for this course is a series of six lectures each on Thursday and Friday. Dr. Lewis M. Hurxthal will give the lectures on Clinical Diagnosis, Dr. Hugh F. Hare those on Roentgenology, and Dr. William Meissner those on Laboratory and Pathological Diagnosis. All three are from the Lahey Clinic, Boston. On Saturday Dr. Hurxthal will give two lectures summing up the material presented on the previous two days and with the other two lecturers will hold a special question and answer period and round table discussion. These lecturers are nationally known, and we are most fortunate to have the opportunity to hear them. The lectures will be well coordinated while they are being prepared. This Seminar is designed primarily for diagnosticians, internists and those physicians desiring to improve their diagnostic acumen.

The Twentieth Annual Graduate Short Course will be held as usual the last week in June, 23-28 inclusive. There will be several changes in the instructors this year, some of whom have already been secured. The Faculty will be announced later. Again this year the extra lectures coming the first three days will be devoted to Diseases of the Chest. The speaker will be outstanding in this field.

* * * *

The division chairmen of the Department of Medicine agreed unanimously to offer one day sessions in various cities throughout the state at the request of the county societies. Suggestions have been received, and plans are being made to present this graduate work to the physicians.

Second Annual Medical Seminar Mount Sinai Hospital

"Recent Advances in Diagnosis and Treatment" has been selected as the topic for a three day intensive postgraduate course at the Second Annual Medical Seminar of the Mount Sinai Hospital, Miami Beach, May 22-24, 1952.

Included among outstanding physicians from throughout the nation who will participate in the seminar are: Dr. James H. Means, Professor of Clinical Medicine at Harvard Medical School; Dr. William Dameshek, Professor of Clinical Medicine at Tufts College Medical School, Boston; Dr. D. M. Bergenstal and Dr. Joseph B. Kirsner, University of Chicago, The School of Medicine; Dr. Rachmiel Levine, Director of the Department of Metabolic and Endocrine Research at Michael Reese Hospital, Chicago; Dr. Daniel C. Darrow, Professor of Pediatrics, Yale University School of Medicine; and Dr. Robert Elman of the Department of Surgery at the Washington Universty School of Medicine, St. Louis.

Chairman of the Seminar Committee is Dr. Paul N. Unger, assisted by Dr. David A. Nathan, Dr. S. Charles Werblow, and Dr. Richard M. Fleming. Assisting committee chairmen are: Dr.

Louis Lemberg, Dr. Jandon Schwarz, Dr. Samuel B. Kleinman, Dr. Leo M. Levin, and Dr. Paul Plotkin.

Registration fee is $20. An additional $7.50 will be necessary for those planning to attend the banquet. Interns and residents will not be required to pay a registration fee.

Highlights of Los Angeles A. M. A. Clinical Session

Surpassing numerically all expectations, the success which attended the Fifth Clinical Session of the American Medical Association at Los Angeles last December reflects the best tradition of the Far West and sets a high goal for future host cities to attain. Denver, coming next with this year's meeting on December 2-5, faces a real challenge to meet the Los Angeles record, as does St. Louis in '53. Then comes Miami in '54, and every member of the Florida Medical Association will anticipate with pleasure the opportunity to help make the Eighth Clinical Session here in Florida altogether as outstanding as any of the preceding meetings.

At the Los Angeles meeting there were more than twice as many registrations as at the Cleveland meeting in 1950. Physicians registering numbered 4,419 and guests 4,656, a total of 9,075. This was by far the largest clinical meeting yet held. The two day Public Relations Conference preceding the clinical session likewise attracted a record attendance, totaling 450. The 39 newspaper and magazine writers covering the clinical session comprised the largest group ever assigned for this purpose.

Some 7,000 persons crowded into the auditorium of the Shrine Convention Hall for the nonpartisan public forum appearance which this great nonpartisan professional organization afforded Senators Robert A. Taft and Harry F. Byrd, who warned against the dangers of "creeping socialism." About 2,000 others could not be admitted because of lack of space.

"The next year," said President John W. Cline of San Francisco in his address to the House of Delegates, "will be one of important decision. . . . If we are to protect our heritage of freedom . . . this decision must be correct. . . . Should this country continue on the road which leads to socialism, those things which we cherish will be irrevocably lost."

Making a surprise appearance before the House of Delegates, Donald R. Wilson of Clarksburg, W. Va., National Commander of the American Legion, declared that "three million members of the Legion stand shoulder to shoulder with you, as doctors, in your battle to overcome the encroaching forces of socialized medicine."

Said Dr. Elmer L. Henderson of Louisville in his report to the House as chairman of the A. M. A. Campaign Coordinating Committee, "The election year ahead is perhaps the most critical year of the medical profession's existence as a free society, dedicated to the health of the nation, unhampered by politics."

Still in active practice after half a century of service, Dr. Albert C. Yoder of Goshen, Ind., at the age of 84 became the choice for the A. M. A. general practitioner of the year. Reminiscing about the "good old days," Dr. Yoder said, "Back in 1903, I had my first appendectomy, on a college student . . . on a kitchen table . . . patient made a nice recovery . . . later went on to medical school. . . ." It was this same patient who suggested Dr. Yoder's name for nomination as Indiana's family doctor, which proposal led eventually to his selection for the fifth annual general practitioner's award at the Los Angeles meeting.

Report of Delegates to A. M. A. Atlantic City, June 11-15, 1951

The one hundredth annual session of the American Medical Association was held in Atlantic City, N. J., June 11-15, 1951. This was the first year the Florida Medical Association had three representatives in the House of Delegates. The ratio is based on the number of active members of our association who are also members of the A. M. A.

The House of Delegates was called to order by the Speaker, Dr. F. F. Borzell of Philadelphia at 10 a. m. June 11. In his address he stated in part that, "The passing years have not eased our tasks or reduced our responsibilities. On the contrary, because our predecessors have built so well, we find ourselves in the forefront of a struggle for the preservation of the very fundamentals of those principles which make life worth living. There have been times when clouds were dark and it looked as though our structure would crumble, but I say to you in all sincerity that the American Medical Association was never stronger than it is today."

The retiring president, Dr. Elmer L. Henderson, Louisville, Ky., delivered a splendid address covering many details on "Objectives for the Future." He paid high tribute to Whitaker and Baxter for their outstanding work in behalf of freedom in medical practice through the National Education Campaign.

The Chairman of the Board of Trustees, Dr. Louis Bauer, Hempstead, N. Y., made a detailed report to the House. Among the many items mentioned were hospital standardization by a joint committee of the American Medical Association, the American College of Surgeons, the American College of Physicians and the American Hospital Association. Dr. Bauer through his many years of hard work in the Association knows all the answers. He was honored as the president-elect.

The local committee on arrangements for the clinical session in Houston, Texas, recommended that the meeting be canceled because of the unavailability of suitable facilities. Therefore, the Board of Trustees accepted an invitation to meet in Los Angeles, Dec. 4-7, 1951. Through the efforts of your two senior delegates the Clinical Session will be in Miami in 1954.

Many and various resolutions were presented to the House which were referred to the reference committees for hearings and recommendations. The entire proceedings of the House of Delegates were published in the A. M. A. Journals of June 30 and July 7, 1951. You are referred to those two issues for detailed information. Dr. R. S. Kneeshaw of California presented a resolution that should be of interest to all of us. It requested the Board of Trustees to establish a system of preceptorship for the instruction of medical students in the art and economics of the practice of medicine, such a system to be organized within the framework of the Student American Medical Association and with the aid and approval of the local county medical society.

The House voted Dr. Allen O. Whipple, New York City, the distinguished Service Award for 1951.

Dr. John W. Cline, San Francisco, was installed as president. He is recognized as a great leader with ability and sound judgment. In his address he pointed out that medical progress in the last half century has added twenty years to man's life span, reduced maternal mortality to the lowest in the world and cut infant deaths thirty-eight per cent in the last decade.

The registration of F. M. A. members at the meeting in Atlantic City was 136. Your two senior delegates to the American Medical Association are doing a splendid job in representing Florida. They are most competent and have been recognized in being given important appointments. Dr. Homer L. Pearson, Jr., Miami, has been a member of the Judicial Council for some time while Dr. Louis M. Orr, II, Orlando, is chairman of the Reference Committee on Hygiene and Public Health. Ability with seniority means a great deal in the House of Delegates. If these two gentlemen are continued as your delegates, it is believed that Florida will eventually be represented on the Board of Trustees.

It was my honor to have served as one of your delegates back from 1936 to 1940. During that time I served on several reference committees. I am grateful for the honor of again representing Florida with Doctor Pearson and Doctor Orr.

Respectfully submitted,
Herbert L. Bryans, M.D.

Report of Delegates to A. M. A. Los Angeles, Dec. 4-7, 1951

The Fifth Annual Clinical Session and the mid-year meeting of the House of Delegates of the American Medical Association was held in Los Angeles, Dec. 4-7, 1951.

The House was called to order at 10:00 a.m., Tuesday, December 4, by the Speaker, Dr. F. F. Borzell.

We were addressed by the President, John W. Cline, who spoke forcefully about our political obligations and the importance of holding the advanced positions we have gained. He said, "We must never let it be necessary for American Medicine to be on the defense again."

Past President, Elmer Henderson, Chairman of the National Educational Campaign Committee, made a fine report on the accomplishments of the committee to date. He also announced that after Jan. 1, 1952 Whitaker and Baxter would no longer be employed full time by the American Medical Association, but would continue on part time. It is the feeling that the Department of Public Relations of the Association now has developed to the degree that it can, with the aid of Whitaker and Baxter and the doctors of America, do a good public relations job in the future.

Dr. Henderson also reported on the American

Medical Education Foundation as follows: The response of physicians to the cause was lamentable in that so few had contributed so little. If we cannot support our own program how can we expect others to do so? The Board of Trustees donated another $500,000 to the Foundation on behalf of the American Medical Association. The doctors of America are called upon to contribute $100 each annually to medical education.

Many committee reports were made and a number of resolutions presented, the contents of which may be found in the December 22 issue of the A. M. A. Journal. The Constitution and By-laws of the Association are being changed, subject to final action at the June 1952 session, so that there will be no more fellowships. Fellowship dues for 1952 have been abolished. A. M. A. membership dues for 1952 are $25 which include the Journal.

The Hess report of two years ago was referred back to the House revised and adopted. This report had to do with the practice of medicine by hospitals and it contained certain recommendations which were deemed unwise.

On Wednesday evening at seven o'clock addresses to the House by Senator Robert A. Taft and Senator Harry F. Byrd were heard and approved. These addresses were broadcast over coast to coast hookup and were forceful in denouncing the trend of our Government to socialism in general, and denouncing socialism in medicine in particular. The December 15 issue of the A. M. A. Journal carries these addresses in full.

The next meeting of the American Medical Association will be in Chicago, June 9-13, 1952.

The Senior Delegate served this House of Delegates as Chairman of the Medical Affairs Reference Committee. Both Delegates attended all sessions.

Respectfully submitted,
Homer L. Pearson, Jr., M.D.
Louis M. Orr, II, M.D.

RESERVE THESE DATES

APRIL 27, 28, 29, 30, 1952

FOR THE CONVENTION IN

HOLLYWOOD

YOUR BLUE SHIELD

Blue Shield Questionnaire

By this time all licensed physicians in the State should have received a questionnaire from the Florida Blue Shield Plan and their cooperation is asked in completing this questionnaire and returning it to the Plan as soon as possible.

The questionnaire was developed to enable the Plan to get to know the physicians a little better and to enable the physicians to express their feelings about participating more actively in the Plan.

In reading through the questionnaire one will note that the first part of it is devoted to pertinent information about the physician's specific practice, which information is most helpful in the administration of the Blue Shield Plan. The physician is then asked about his knowledge of Plan organization and policies and whether or not he would be interested in serving on a Public Relations Committee for Blue Shield in his County Medical Society. The function of such a Public Relations Committee would be to keep the society posted on policies and progress of Blue Shield and to serve as liaison between the medical society and the Plan. The questions which follow pertain to the physician's office staff and their knowledge of Blue Shield reports and procedures.

Blue Shield is constantly striving to determine ways and means of better serving the participating physicians and it is believed that the physicians themselves can help the Plan develop a worthwhile program of physicians' relations by completing the questionnaire and returning it to the Plan promptly.

STATE BOARD OF HEALTH

Creeping Eruption Survey

In an effort to estimate the extent of the creeping eruption (larva migrans) problem in Florida and to determine the various types of treatment recommended by practicing physicians, a post card survey was conducted by the Florida State Board of Health.

During the month of August 1951, post cards were sent to 2,600 physicians in Florida. These physicians were asked to report the number of cases of creeping eruption which they had treated

within the last six months and to give their recommendations as to therapy. There were 1,186 cards returned, representing 45.6 per cent of the number sent out. Five hundred and sixty-two physicians reported no cases treated, and 624 physicians reported a total of 7,928 cases.

Cases of creeping eruption were reported from all counties in Florida with the exception of Flagler, Gilchrist, Glades, Liberty, Santa Rosa, Union and Wakulla. Thirty-seven of the physicians gave their choice of therapy. The three drugs used most often were hetrazan, ethyl chloride, and fuadin. These were given either alone or in combination with other drugs.

Table 1 presents a breakdown showing the types of treatment used by the physicians of the state, the number of physicians using the treatment indicated, and the percentage of the thirty-seven physicians who indicated their choice of therapy.

Table 1. — Analysis of Types of Treatment

Treatment	Physicians Reporting	Per Cent
Hetrazan	7	18.9
Hetrazan and ethyl chloride	4	10.8
Ethyl chloride	9	24.3
Ethyl chloride and local application of ointments	3	8.1
Fuadin	4	10.8
Fuadin and ethyl chloride	3	8.1
Worm treatment (?)	1	2.7
Bichloracetic acid	1	2.7
Ammoniated mercury, fatty acid ointments, and roentgen rays	1	2.7
Potassium permanganate followed by pragmatar	1	2.7
Phenol and 5 per cent salicylic acid in collodion	1	2.7
Libradol (contains nicotine)	1	2.7
Roentgen rays	1	2.7

Studies have been made as to the number of cats and dogs that have the parasites Ancylostoma braziliense and Ancylostoma caninum. A report made by A. W. Donaldson, Sc.D., J. H. Steele, D.V.M., and James E. Scatterday, D.V.M.,* showed that in Florida, in 1950, out of 495 dogs on which a postmortem examination was performed, 219 (44.2 per cent) were infected with A. braziliense, and 426 (86.1 per cent) harbored either A. braziliense or A. caninum or both. Of 26 cats examined, seven were positive for A. braziliense and 22 for one or the other or both species of the hookworm.

This same investigation showed that control measures similar to those against the human hookworms are applicable. In addition, the application of chemical agents such as calcium cyanamide or sodium borate to the soil to kill free-living stages offers some promise of success; however, these findings are not too practical for the control of this disease at the present time.

*From the "Proceedings Book," American Veterinary Medical Association, Eighty-seventh Annual Meeting, Miami Beach, Aug. 21-24, 1950, pp. 83-88.

BIRTHS AND DEATHS

Births

Dr. and Mrs. Harold Carron of Tampa announce the birth of a son on December 8.

Dr. and Mrs. Richard M. Fleming of Miami announce the birth of a daughter, Susan Marion, on December 11.

Dr. and Mrs. Wray D. Storey of Tampa announce the birth of a daughter on December 22.

Dr. and Mrs. Oliver F. Deen, Jr., of Tampa announce the birth of a daughter.

Dr. and Mrs. Joseph J. Lowenthal of Jacksonville announce the birth of twin daughters, Jan A. and Janet B., on January 12.

Dr. and Mrs. William A. Van Nortwick of Jacksonville announce the birth of twin daughters, Nina Grace and Clare Kathryn, on January 12.

Deaths — Members

Stanford, John A., Ft. Lauderdale ..... Dec. 27, 1951
Sandusky, Clarence M., Jacksonville ..... Dec. 29, 1951

Deaths — Other Doctors

Stutts, Baldwin S., Dunnellon ..... Dec. 27, 1951
Martorell, Abelardo, Tampa ..... Dec. 31, 1951

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Baggs, Wade H., Jr., Tampa
Banks, Cullen W., II, (Col.), Gainesville
Edwards, Harry M., Ocala
Frishkorn, Paul E., Auburndale
Garner, Joe F., Jacksonville
Hodges, William A., Jr., Lakeland
Jensen, Louis C., Jr., Winter Haven
Jones, Frederick B., Chipley
Karelas, George W., Newberry
McKay, Charles F., Lake Butler
Massam, Alfred S., Bartow
Moody, James D., Orlando
O'Donnell, John A., Daytona Beach
Pinkoson, Charles, Gainesville
Price, Robert N., Lakeland
Rahilly, George T. F., Fort Lauderdale
Schildecker, William W., Daytona Beach
Smith, Vincent V., Fort Lauderdale
Thomas, Joseph E., Mulberry
Wiltshire, Joseph A., (Col.), Lake Wales

STATE NEWS ITEMS

Dr. Eugene L. Jewett of Orlando, representing Florida, was one of about 50 doctors appointed from the hundreds attending the Pan-Pacific surgical Congress in Honolulu in November to act as emissary of modern medical science at ceremonies rededicating the ancient Hawaiian healing heiau atop Aiea heights near Honolulu. In effect, modern medicine was admitted to the shrine and thus linked to the ancient Hawaiian art of herbal healing.

Dr. Ruth S. Jewett (Mrs. Eugene L. Jewett) of Winter Park was the only other Florida doctor present at the ceremony.

Dr. Charles Rosenfeld of Miami has returned to his practice after completing a two weeks postgraduate course in the care of premature infants at the New York Hospital, Cornell Medical Center.

Every member of the Board of Governors was present at the December 16 meeting in Jacksonville. The Board met at the call of its chairman, President David R. Murphey, Jr., of Tampa.

Meeting simultaneously with the Board was the Scientific Work Committee of which Dr. James N. Patterson of Tampa is chairman. The committee completed the scientific program for the 1952 convention at Hollywood, April 28-30.

Dr. David Henry Poer of Atlanta, Secretary-Treasurer of the Medical Association of Georgia and Editor of The Journal, has been invited by the Board of Governors to attend the F. M. A. annual meeting in April representing his Association. Dr. Poer had expressed admiration for the progressiveness of the F. M. A. and a desire for an opportunity to see it in action.

Word has been received from Korea that Mr. Harold Parham, on leave of absence from the Bureau of Public Relations, has been promoted to the rank of first lieutenant.

Dr. John D. Milton of Miami presented a paper at the annual meeting of the Florida Obstetric and Gynecologic Society held in St. Petersburg, December 1-2.

Dr. Chas. L. Farrington, St. Petersburg, was the featured speaker at a one-day meeting of public health nurses from the Gulf coast counties. Dr. Farrington was also guest speaker at the meeting in early December of the Tarpon Springs Rotary Club where he spoke on various methods used in correcting deformities in crippled children.

Dr. James N. Patterson of Tampa and Dr. O. Whitmore Burtner of Miami recently conducted a seminar on Hematology in Tampa, sponsored by the Florida Society of Medical Technologists.

Dr. Samuel G. Hibbs of Tampa has been elected vice-president of the Tampa chapter, American National Red Cross.

Dr. James J. Griffitts of Miami explained to the local Rotary Club at a recent meeting the necessity for large numbers of blood transfusions in that area.

Dr. Joseph Perez of DeLand addressed a local Lions Club at a recent meeting on methods of caring for injuries due to atomic explosion.

Dr. John R. Boling, Tampa, has been honored by the St. Joseph's Hospital for his 17 years of service as Chief of Staff.

Dr. Thomas H. Bates of Lake City has been reappointed for the fifth time to the Medical Advisory Committee to the Nation Rehabilitation Commission of the American Legion.

Dr. Walter H. Winchester of Dunedin was the guest speaker at a recent meeting of the Kissimmee Rotary Club.

Dr. William C. Roberts, Panama City, has been elected president of a newly-formed medical-social group. The organization is separate from the county medical society. Other officers include Dr. James A. Poyner, vice-president, and Dr. Harold E. Wager, secretary-treasurer, both of Panama City.

Again this year complimentary subscriptions to "Today's Health" are being sent by the Association to United States Senators and Congressmen, Florida Senators and Representatives, the Governor and members of his cabinet, the Director of the Florida Agricultural Extension Service, and the Florida State Home Demonstration Agent.

Dr. Otho W. Gardner of Greensboro was signally honored by friends and former patients on his 77th birthday December 11. The birthday party was attended by approximately 1,000 people, 500 of whom were Dr. Gardner's "babies." Dr. Gardner estimates that he has delivered over 3,000 babies during his 50 years of medical practice. During this time he was the only physician in Greensboro and served as mayor of the town for 37 years.

Dr. Gardner, a native of Camilla, Ga., came to Greensboro to practice shortly after he received his degree from what is now the Emory University School of Medicine in Atlanta in 1901. He still practices medicine part time in his home.

Mr. Norman J. Ulbright of St. Louis has joined the Association as acting supervisor of its Bureau of Public Relations, which functions under the general direction of Dr. Stewart G. Thompson, Managing Director.

Mr. Ulbright, formerly public relations director of Optimist International, a service club organization, is a graduate of the University of Missouri and comes to the Association with an impressive background in public relations and organization work.

Dr. M. Eugene Flipse, who has been taking postgraduate work in internal medicine and the subspecialty of pulmonary diseases at the Mayo Foundation, plans to spend an additional year at the Foundation studying cardiovascular diseases. Upon completion of his studies, Dr. Flipse plans to re-establish his practice in Miami.

Dr. Bernard J. McCloskey of Jacksonville has returned to his practice following a postgraduate course in cardiovascular diseases at the University of Texas, December 10-15.

Dr. Milton F. Saslaw of Miami announces that courses of instruction in cardiology will be offered at the National Children's Cardiac Home, Miami, in the near future.

Dr. J. Maxey Dell, Sr., Gainesville, was honored on December 14 by the local lodge of the Elks as one of the members present at the organization of the lodge in 1906.

Dr. Ivan W. Gessler of Winter Haven recently spoke before the local Rotary Club explaining the code of ethics of the medical profession. On the program with Dr. Gessler was a member of the legal profession and a newspaperman.

Dr. J. Powell Adams of Panama City was a recent guest speaker at a monthly meeting of a local Parent Teacher's Association. Dr. Adams discussed the importance of contributing blood through the mobile blood unit.

Dr. Richard S. Hodes formerly of Barberville has announced the opening of his offices at 420 West Lafayette Street, Tampa, with practice limited to anesthesiology.

Dr. Walter C. Payne, Pensacola, chairman of the Association's Grievance Committee and member of the Board of Governors, visited the headquarters office in Jacksonville, January 14, to discuss problems in connection with affairs of the Association.

Dr. Henry B. Cordes of Frostproof was honored by the local Rotary Club for 31 years of service to the community. His record was reviewed for the club by Dr. Kenneth Dunham, also of Frostproof.

Dr. Franz H. Stewart of Miami discussed "Ethics of the Medical Profession" at a meeting of a local Exchange Club.

The Georgia Society of Ophthalmology and Otolaryngology will hold its annual meeting Friday and Saturday, March 7 and 8, 1952, at the well known resort hotel, The General Oglethorpe, Wilmington Island, Savannah, Ga. For additional information, write Dr. W. Eugene Matthews, Secretary-Treasurer, Augusta, Ga.

The Southeastern Allergy Association will hold its Seventh Annual Meeting at the Bon Air Hotel, Augusta, Ga., on March 21 and 22, 1952.

Dr. Lewis T. Corum of Tampa presented a scientific paper at the January meeting of the DeSoto-Hardee-Highlands-Glades Medical Society on "Some Common Problems of Early Infancy."

Dr. Hawley H. Seiler of Tampa was the guest speaker at a recent meeting of the Polk County Medical Society held at the Lakeland Yacht Club. His subject was "The Surgical Treatment of Solitary Pulmonary Metastases" and "Indications for Pulmonary Resection in the Treatment of Tuberculosis."

COMPONENT SOCIETY NOTES

Alachua

New officers of the Alachua County Medical Society are Dr. Henry J. Babers, Jr., president; Dr. Henry H. Graham, vice-president; and Dr. Raymond S. Camp, secretary-treasurer, all of Gainesville.

Bay

At the regular monthly meeting of the Bay County Medical Society officers for 1952 were elected as follows: Dr. Charles H. Daffin, president; Dr. Jack Corbitt, vice-president, and Dr. William F. Humphreys, Jr., secretary-treasurer, all of Panama City.

Brevard

At the regular December meeting of the Brevard County Medical Society officers were elected for the year 1952. Dr. James A. Sewell of Melbourne was elected president, Dr. Laurent L. LaRoche of Cocoa was elected vice-president, and Dr. Theodore J. Kaminski of Melbourne was re-elected secretary-treasurer.

Guests at the meeting were doctors from Patrick Air Force Base and the Florida Rapid Treatment Center.

Broward

Guest speaker at a recent meeting of the Broward County Medical Society was Dr. Clarence M. Sharp, Director of the Bureau of Tuberculosis Control, State Board of Health, who spoke on the recent improvements at the state tuberculosis hospital at Lantana.

Dade

Dr. Ralph S. Sappenfield will serve as president of the Dade County Medical Association for 1952. Other officers elected at the regular December meeting include: Dr. Ralph W. Jack, Miami, president-elect; Dr. Benjamin G. Oren, Miami, vice-president; Dr. Nelson Zivitz, Miami Beach, secretary, and Dr. Raymond L. Evans, Miami, treasurer.

Some fifty representatives of press, radio and television in the Miami area were guests of the Association at its third annual medical-press-radio dinner, December 5. The program was under the direction of Drs. L. Washington Dowlen, Edward W. Cullipher and Robert F. Dickey.

DeSoto-Hardee-Highlands-Glades

Officers elected to serve the DeSoto-Hardee-Highlands-Glades County Medical Society for 1952 are Dr. Harold S. Agnew, president; Dr. Gordon H. McSwain, vice-president, and Dr. Charles H. Kirkpatrick, secretary-treasurer, all of Arcadia.

At the regular monthly meeting on January 8, Dr. Lewis T. Corum of Tampa spoke on "Some Common Problems of Early Infancy."

Duval

At the regular December meeting of the Duval County Medical Society, the 1952 officers were elected. They are Dr. Ferdinand Richards, president; Dr. W. W. Rogers, president-elect; Dr. Ernest W. Veal, vice-president; Dr. Joseph A. J. Farrington, secretary, and Dr. Bert H. Malone, treasurer, all of Jacksonville.

The regular January meeting was held Jan. 2 at the Naval Hospital, Naval Air Station, Jacksonville. Members of the society were the guests of the medical staff of the hospital. The program included talks on "Acute Head Injury" with case presentation by Lt. (jg) S. C. Taylor, (MC) USNR; "Malignant Dysgerminoma" with case presentation by Cdr. R. B. Greenman, (MC) USN;

and "Recent Advances in Cardiology" by Cdr. M. M. Driskell, (MC) USN.

Escambia

Officers of the Escambia County Medical Society for 1952 are Dr. Chas. J. Heinberg, Pensacola, president; Dr. Stanley G. Childers, Cantonment, vice-president, and Dr. Raymond B. Squires, Pensacola, secretary-treasurer.

Franklin-Gulf

The following officers for 1952 were elected by the Franklin-Gulf County Medical Society: Dr. John W. Hendrix, Port St. Joe, president; and Dr. William P. Blackmon, Apalachicola, secretary.

Hillsborough

New officers of the Hillsborough County Medical Association include Dr. Sherman B. Forbes, president; Dr. Arthur R. Knauf, president-elect; Dr. C. Frank Chunn, vice-president; Dr. James N. Patterson, secretary; and Dr. Thomas F. Nelson, treasurer, all of Tampa.

The Association met with the Pinellas County Medical Society at their December 3 meeting to hear a talk on "Lobotomy in the Treatment of Disabling Psychoneuroses" by Dr. Walter Freeman, famous brain surgeon of Washington, D. C.

At the regular monthly meeting, January 8, members heard a talk on "Recent Advances in Intracardiac Surgery" by Dr. Robert P. Glover of Philadelphia.

Indian River

Officers elected to serve the Indian River County Medical Society for 1952 include: Dr. P. T. McClellan, president; Dr. John P. Gifford, vice-president; and Dr. William L. Fitts, 3rd, secretary-treasurer. All the officers reside in Vero Beach.

Jackson-Calhoun

At the December meeting of the Jackson-Calhoun County Medical Society, officers were elected. Dr. Albert E. McQuagge of Marianna was elected president; Dr. Grayson C. Snyder of Blountstown was elected vice-president; and Dr. Francis M. Watson of Marianna was elected secretary-treasurer.

Lake

Officers of the Lake County Medical Society for 1952 are Dr. Robert H. Montgomery of Mount Dora, president; Dr. James R. Hanson of Tavares, vice-president; and Dr. J. Basil Hall of Mount Dora, secretary-treasurer.

Dr. William O. Fowler of Orlando was guest speaker at the monthly meeting of the society, December 5. He also showed a film in color on chest surgery.

The society voted to continue through January and February the program furnished by the Bureau of Health Education of the American Medical Association. The series is entitled "Melody of Life" and is broadcast over Station WLBE, Leesburg.

Lee-Charlotte-Collier-Hendry

The newly-elected officers of the Lee-Charlotte-Collier-Hendry County Medical Society are Dr. John S. Stewart, president; Dr. Joseph L. Selden, Jr., vice-president; and Dr. Harvie J. Stipe, secretary-treasurer, all of Fort Myers.

Leon-Gadsden-Liberty-Wakulla-Jefferson

Dr. Ernest W. Ekermeyer of Tallahassee is the newly-elected president of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society. Dr. Charles F. James, Jr., of Tallahassee was elected vice-president, and Dr. George H. Massey of Quincy was elected secretary-treasurer.

Madison

The new officers of the Madison County Medical Society are Dr. A. Franklin Harrison, president, and Dr. Eugene D. Thorpe, secretary-treasurer, both of Madison.

Manatee

Dr. John E. Granade is the newly-elected president of the Manatee County Medical Society. Other new officers are Dr. Willis W. Harris, vice-president, and Dr. Marjorie L. Warner, secretary-treasurer. All three officers are from Bradenton.

Marion

The following officers for 1952 were elected by the members of the Marion County Medical Society at the December meeting: Dr. Carl S. Lytle, president, and Dr. William J. McGovern, vice-president. Re-elected secretary-treasurer was Dr. Bertrand F. Drake. All officers reside in Ocala.

Dr. Harry M. Edwards of Ocala spoke on "Diarrhea in Infants and Children."

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Monroe

Officers for the Monroe County Medical Society for 1952 are Dr. James B. Parramore, president; Dr. Leonard H. Conly, vice-president; and Dr. Herman K. Moore, secretary-treasurer, all of Key West.

Nassau

Dr. David G. Humphreys was re-elected president of the Nassau County Medical Society for 1952. Also re-elected were Dr. Benjamin F. Dickens, vice-president, and Dr. John W. McClane, secretary-treasurer. All three officers are from Fernandina.

Orange

The newly-elected officers of the Orange County Medical Society are as follows: Dr. Carl S. McLemore, president; Dr. G. Tayloe Gwathmey, president-elect; Dr. Edgar E. Hitchcock, vice-president; Dr. James B. Glanton, secretary, and Dr. Joseph C. Hayward, treasurer, all from Orlando.

At the regular December meeting of the society, Mr. Jefferson Hamilton, consulting architect for the proposed medical school at Gainesville, was guest speaker. He discussed the present plans for this medical school.

Palm Beach

Dr. Cecil M. Peek, West Palm Beach, is the new president of the Palm Beach County Medical Society. Other officers include Dr. Alvin E. Murphy, Palm Beach, vice-president; Dr. Graham W. King, Jr., Delray Beach, president-elect; Dr. David A. Newman, West Palm Beach, secretary; and Dr. Frederick K. Herpel, West Palm Beach, treasurer.

The first edition of a Directory of the Physicians and Surgeons in Palm Beach County has been issued by the Palm Beach Medical Society .

Pasco-Hernando-Citrus

At the regular monthly meeting of the Pasco-Hernando-Citrus County Medical Society on December 13, the following officers were elected for the year 1952: Dr. William H. Walters, Jr., Lacoochee, president; Dr. George R. Creekmore, Brooksville, and Dr. Karl T. Humes, Bushnell, vice-presidents; and Dr. W. Wardlaw Jones, Dade City, secretary-treasurer.

Pinellas

The list of officers who will serve the Pinellas County Medical Society during 1952 appeared in the December Journal.

At the December meeting of the Society, Dr. Walter Freeman, neuro-psychiatrist and neuro-surgeon of Washington, D. C., spoke on "Lobotomy in the Treatment of Disabling Psychoneuroses," to a joint assembly of members of the Pinellas and Hillsborough Societies.

The regular monthly meeting of the Society was held on January 7 at the Detroit Hotel in St. Petersburg. Dr. William R. Tench of Clearwater presented a scientific paper on "Electrolyte Balance of the Body."

Polk

At its regular meeting in December, the Polk County Medical Society held its annual election of officers. Elected were Dr. Ivan W. Gessler of Winter Haven, president; and Dr. Milo H. Holden of Bartow, vice-president. Dr. Jere W. Annis of Lakeland was re-elected secretary-treasurer.

At the regular meeting in January, Dr. Hawley H. Seiler of Tampa was guest speaker. His subject was "The Surgical Treatment of Solitary Pulmonary Metastases" and "Indications for Pulmonary Resection in the Treatment of Tuberculosis."

Putnam

Dr. Lawrence G. Hebel was elected president of the Putnam County Medical Society for 1952, and Dr. Bennie J. Massey was elected secretary-treasurer. Both are from Palatka.

St. Johns

At its regular meeting in December, the St. Johns County Medical Society held its annual election of officers. Elected were Dr. Charles C. Grace, president; Dr. George C. Hopkins, vice-president; Dr. James J. DeVito, secretary; and Dr. Reddin Britt, treasurer, all of St. Augustine.

St. Lucie-Okeechobee-Martin

The newly-elected officers of the St. Lucie-Okeechobee-Martin County Medical Society are Dr. Richard F. Sinnott, president, and Dr. John T.

Advertisement

From where I sit *by* Joe Marsh

Jiggs Gets Four "Hot-Foots"

Cappy Miller's bought himself a new car. We won't be seeing his old jalopy bouncing over the back roads any more. I'm going to miss it, too.

Many a morning Cappy and I drove off in that rattletrap for a day's hunting or fishing. We'd pile rods or guns in back, and prop open the trunk compartment—so Jiggs, Cappy's pointer, could jump in and go along.

They say when Cappy brought the new car home he opened up the hood to show off the engine—and poor old Jiggs hopped right in! Figured it was the trunk. He hopped right out in a hurry, too. That cylinder head was mighty hot.

From where I sit, old habits are hard to shake, once they get a hold. For instance, too many people are still in the habit of trying to run their neighbors' lives—telling them how to act, how and where to practice their profession, whether or not to enjoy a glass of beer. I say that kind of thinking's outmoded . . . ought to be turned in for a new model!

Joe Marsh

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McDermid, vice-president. Re-elected secretary-treasurer was Dr. Adrian M. Sample. All officers are from Ft. Pierce.

Dr. Robert F. Dickey of Miami, guest speaker, spoke on "Reparative Surgery in Children."

Seminole

Officers elected to serve the Seminole County Medical Society during 1952 are: Dr. Julian N. Tolar, president; Dr. William V. Roberts, vice-president; and Dr. Frank L. Quillman, secretary-treasurer, all of Sanford.

Suwannee

Dr. Edward G. Haskell, Jr., of Branford is the newly-elected president of the Suwannee County Medical Society. Other officers include Dr. Irby H. Black, vice-president; and Dr. J. Dillard Workman, secretary-treasurer, both of Live Oak.

Volusia

Officers of the Volusia County Medical Society for 1952 were elected at the December meeting. Dr. J. Richard West was elected president; Dr. C. Robert DeArmas was elected vice-president, and Dr. Robert L. Miller was re-elected secretary-treasurer. All are from Daytona Beach.

Walton-Okaloosa

Officers of the Walton-Okaloosa County Medical Society for 1952 are Dr. William D. Cawthon, DeFuniak Springs, president; Dr. Allen A. Enzor, Crestview, vice-president; and Dr. Edgar H. Myers, DeFuniak Springs, secretary-treasurer.

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Washington-Holmes

Officers of the Washington-Holmes County Medical Society for 1952 are Dr. George W. Carter, president, and Dr. Bayllye W. Dalton, secretary-treasurer, both of Chipley.

BOOKS RECEIVED

Rehabilitation Nursing. By Alice B. Morrissey. Pp. 299. Price, $5.00. New York, G. P. Putnam's Sons, 1951.

From the pen of the Supervisor of Nursing Service and Instructor of the Rehabilitation Center, Department of Physical Medicine and Rehabilitation, Bellevue Hospital, New York City, this book embodies the author's sound philosophy of patient care and offers the reader an opportunity to gain knowledge that can be applied to every area of nursing. Although the special theme is rehabilitation nursing, it contains so much good basic nursing that it should prove both profitable and inspirational to all nurses and nursing students who take pride in their vocation and harbor a genuine desire to aid their patients in restoring themselves.

This unique contribution to present day nursing literature presents first a short historical approach and then offers specific details of nursing technics and procedures to be employed in caring for patients who suffer from some of the more common disabling conditions. The methods suggested are entirely patient-centered. The role of the nurse is pictured in the combined capacity of nurse, teacher, helper and friend. Great emphasis is placed upon the psychologic problems involved in teaching the patient to assist in the rehabilitation process.

In the foreword, Dr. Howard A. Rusk commends this book as a guide to the nurse in helping minimize the disability resulting from many chronic disabling diseases medical science cannot as yet prevent or cure and as an aid to her in helping her patients learn to live within the limits of their disabilities and to the hilt of their capabilities.

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The carbohydrates in Baker's Modified Milk are lactose and dextrose. The dextrose which requires no digestion is readily assimilated. The lactose is slowly digested and absorbed. This combination of sugars is less likely to lead to digestive disturbances than if a single sugar were used. The carbohydrate content (7% at normal dilution**) provides adequate calories to spare the protein for its normal function of tissue building and repair.

FAT

The fat-carbohydrate ratio (approximately 1:2) is adequate to insure proper fat metabolism. The butter fat has been replaced by other fats containing less of the undesirable very low and very high molecular weight fatty acids. The added fats have also been selected to provide adequate amounts of the essential unsaturated fatty acids.

MINERALS

Baker's Modified Milk contains an adequate mineral content with the calcium-phosphorus ratio falling within the optimum range (1.3 to 1). Since cows milk contains only a trace of iron, sufficient iron ammonium citrate has been added to supply 7.5 milligrams of iron per quart of normal dilution.**

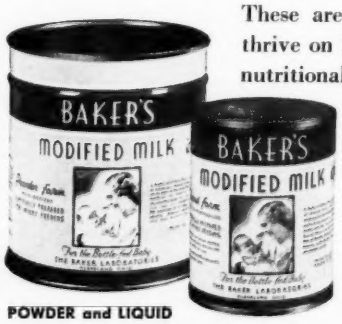
VITAMINS

Baker's Modified Milk supplies adequate amounts of all recommended vitamins except Vitamin C.

These are the reasons why infants thrive on Baker's Modified Milk—a nutritionally adequate* formula.

★

Made from Grade A Milk (U.S. Public Health Service Milk Code) which has been modified by replacement of the milk fat with vegetable and animal fats by the addition of carbohydrates, vitamins and iron.



POWDER and LIQUID

*When fed in normal quantities, provides amounts of proteins, vitamins (except C), minerals and essential unsaturated fatty acids equal to or exceeding the daily recommended allowances of The Food and Nutrition Board of the National Research Council.

**Dilute with equal parts of water.

BAKER'S MODIFIED MILK

THE BAKER LABORATORIES INC.

Main Office: Cleveland, Ohio
Plant: East Troy, Wisconsin

Division Offices: Atlanta, Dallas, Denver, Greensboro, N. C., Los Angeles, San Francisco, Seattle

ACCEPTED COUNCIL ON FOODS AND NUTRITION AMERICAN MEDICAL ASSOCIATION